FINAL PROJECT REPORT

October 2003 - September 2006

HEALTH COMMUNICATION PARTNERSHIP

NEPAL

Valued Behavior For Healthy Families - A Model for Social Inclusion

Mobilizing Communities | Enhancing Links between Services and Communities | Expanding Quality Family Planning Services | Advocacy with Religious Leaders

Submitted to: USAID/Washington

By: Health Communication Partnership Nepal

Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs and Save the Children US with implementing partner NGOs: Kirat Yakthum Chumlung/ Punarjivan Kendra – Sunsari District, Indreni Sewa Samaj – Siraha District Community Family Welfare Association – Dhanusha District and UNESCO/Club – Banke District

October 2006

Acronyms

ANC	Antenatal Care
BCC	Behavior Change Communication
CBS	Central Bureau Statistics
CFWA	Community Family Welfare Association
CMC	Center/Class Management Committee
CMWRA	Currently Married Women of Reproductive Age
CPD	Core Program District
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DDC	District Development Committee
DG	Disadvantaged Group
DHO/DPHO	District Health Office / District Public Health Office
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DoHS	Department of Health Services
DS	Drama Serial
EHCS	Essential Health Care Services
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FF	Flexible Funds
FHD	Family Health Division
FP	Family Planning
FM	Frequency Modulator
F/Y	Fiscal Year
GoN	Government of Nepal
HCP	Health Communication Partnership
HMIS	Health Management Information System
HP	Health Post
HF	Health Facilities
HFOMC	Health Facility Operations Management Committee
INGO	International Non-Governmental Organisation
INSES	Indreni Sewa Samaj
IP	Implementation Plan
IR	Intermediate Result
IUCD	Intra-Uterine Contraceptive Devices
JHU/CCP	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs
KYC/PJK	Kirat Yakthum Chumlung/ Punarjeevan Kendra
LGM	Learners Generated Materials
LMIS	Logistic Management Information System
LOP	Life of Project
LQAS	Lot Quality Assurance Sampling

MCH	Maternal Child Health
MCHW	Maternal Child Health Worker
MWRA	Married Women of Reproductive Age
MoHP	Ministry of Health and Population
NDHS	Nepal Demographic Health Survey
NFHP	Nepal Family Health Program
NGO	Non Governmental Organisation
NHSP-IP	Nepal Health Sector Program-Implementation Plan
NHTC	National Health Training Center
PIP	Program Implementation Plan
PLA/RLG	Participatory Learning and Action /Radio Listener Groups
PDQ	Partner Defined Quality
PNC	Post Natal Care
P/NGO	Partner Non-Governmental Organization
PSI	Population Services International
PVO	Private Volunteer Organization
QAWG	Quality Assurance Working Group
QIT	Quality Improvement Team
QoC	Quality of Care
RLG	Radio Listeners Group
RF	Result Framework
RH	Reproductive Health
RHCC	Reproductive Health Coordination Committee
RHP	Radio Health Program
RHTC	Regional Health Training Center
SC/US	Save the Children/US
SHP	Sub Health Post
SSP	Sadbyawahar Swastha Pariwar
ToT	Training of Trainers
USAID	United States Agency for International Development
VDC	Village Development Committee
VHW	Village Health Worker
VSC	Voluntary Surgical Contraception

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Executive Summary

The Demographic and Health Survey of Nepal, (NDHS) 2001 showed that knowledge of at least one method of family planning was nearly universal in Nepal. Also, the Contraceptive Prevalence Rate (CPR) for all methods had risen from 3% in 1976 (Nepal MOH 1976) to 26% in 1996 and then to 39% in 2001(NDHS). Despite this progress, Nepal still faces a high population growth rate of 2.27 % per year (CBS, 2001) and the total fertility rate is still at 4.1. Twenty-eight percent of currently married Nepali women continue to have an unmet need for family planning services, of which 11.4% is for spacing and 16.4% for limiting. Within this overall situation, the contraceptive use among marginalized and disadvantaged communities, including Dalit and Muslim, remains below than the national average. This final report shares a model for Social Inclusion where effective communication had a dramatic, positive effect on the health behaviors of the intended audiences.

With a view to fulfill the reproductive health intentions of Nepal's disadvantaged and marginalized populations, the **'Sadbyawahar Swastha Pariwar'** or **'Valued Behavior for Health Family Project'** was formally launched in four selected districts - namely Sunsari, Siraha, Dhanusha and Banke. The project was implemented by the Health Communication Partnership (HCP) - Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs and SAVE the Children/US (SC/US) - in collaboration with USAID's major bilateral program, the Nepal Family Health Program (NFHP) and the Nepal Government. Field activities were implemented through SC/US's NGO networks. The project was implemented from October 1, 2003 through September 30, 2006.

The overall goal of the project was to help women and couples from disadvantaged groups achieve their reproductive health intention through strengthening the delivery of quality services to the periphery of the health system, linking potential clients with service providers in a way that addressed service related or cultural barriers, increasing informed choice and utilization of FP/RH services and strengthening NGO capacity to improve public sector service quality.

The project used mass media with two mutually supportive community-based approaches to promote increased contraceptive use and other health behaviors. One approach linked localized radio-based entertainment education programs with community based activities. The existing NFHP radio drama serial "Gyan Nai Shakti Ho' (Knowledge is Power) which focuses on Family Planning and Reproductive Health issues was translated into local languages and incorporated into Participatory Literacy & Action/Radio Listeners Groups (PLA/RLGs). PLA/RLGs met six times a week, with two sessions each week serving as a Radio Listeners Groups where groups listened to the program and had a facilitated discussion of the health issues. These PLA/RLGs were supported by additional behavior change communication activities such as miking, postering, community meetings and BCC materials distribution to increase knowledge and create demand for quality reproductive health services. During the three years of project, a total of 374 PLA/RLG classes were conducted comprising 9,321 participants of which 8,768 (94%) were from Dalit and Muslim groups and 553 (6%) members were from other castes.

A second community-based approach, Partnership Defined Quality (PDQ) aimed to improve equity and access to quality health care services. The PDQ approach facilitated a dialogue between health care providers and community members to identify areas where service quality needed improvement, set priorities and develop action plans. The dialogue sought to increase ownership and involvement of community members in their local health facility and to develop shared expectations regarding health care service quality between providers and clients. This would be an important quality improvement process for any community, but was especially key for improving relations between disadvantaged and marginalized communities and health services which have a history of miscommunication and distrust between them. The PDQ process was implemented in a 58 health facilities within the project area by both HCP and the NFHP.

During the initial project assessment, it was found that many of these disadvantaged and marginalized populations were a far distance from health services. In order to increase the intended audiences' access to

quality reproductive health services, family planning services were expanded in the project areas in collaboration with District Public Health Offices and Population Services International.

The project was also geared towards building the capacity of NGO partners in behavior change communication, social mobilization, quality improvement, monitoring and evaluation and improved project management. The project aimed to build NGO staff knowledge and skills in implementing these successful methods for the period of the project and afterwards.

The project succeeded in achieving its objectives and the accomplishment made are note worthy. Project monitoring and evaluation results showed that family planning knowledge and practice increased considerably among the PLA/RLG participants. The proportion of participants who could mention at least three modern FP methods increased almost three times from the pre test level of 26% to 94%. A similar rate of increase was also noticed among the participants who were able to mention at least three sources from where FP services could be obtained from 18% at pre test to 85% at post test. Importantly, the percentage of family planning use among the participants (7,769 eligible couples) increased from 17% at the time of enrollment in June, 2004 to 68% at the end of the project in September, 2006, a 52% increase.

A PLA/RLG study report conducted in 2006 among 1,679 respondents (839 PLA/RLG members and 420 from non PLA/RLG and control areas) revealed that by the end of the project percentage of respondents who were currently using any method of FP was significantly higher among PLA RLG members (44.8 per cent) than those of non-PLA/RLG members and respondents of control areas (36.9 per cent). The project monitoring data conducted among 9321 PLA/RLG members showed that level of contraceptive use among the participants had increased significantly from the level of 39% just before the start of the program activities to 52% in June, 2006. The survey results indicated that the program has been instrumental in increasing the ability of women in different aspects of life as a result of their participation in PLA/RLG. For instance, over 85% of the respondents acknowledged that they became able to use family planning; another 76% said that they became able to talk freely in front of the group while the other 62% respectively claimed that they were able to read and write as a result of their participation in PLA/RLG. Discussion on family planning issues between husband and wife is an internationally recognized proxy for increased ability to adopt FP. In the project areas, spousal discussion was found to be significantly higher among PLA/RLG members and non members than those from control areas. Similarly, a higher percentage (33%) of the PLA/RLG members than non-members (24%) reported having talked about family planning with a health care provider. A great majority of the PLA/RLG members (84%) reported that they had shared their new health knowledge with their friends, neighbor and community members.

PDQ implementation was also found very effective in fostering community ownership and involvement in health services quality improvement, thereby strengthening utilization of services by the poor and marginalized communities. Access to and utilization of family planning and reproductive health services increased substantially as a result of the project intervention. This process proved to be very successful in mobilizing community resources for quality improvement at health facilities, such as construction and maintenance of the health facility infrastructure, strengthening systems and procedures at health facilities, including monitoring and supervision of activities.

Overall, project results demonstrated effectiveness of the integrated design by having a positive impact on marginalized communities' ability to achieve their reproductive health intentions. The project is a model of social inclusion and the methods and results are being widely disseminated among government and I(NGO) partners in order to encourage scale up of this successful model. The report highlights the effective strategies and interventions that the HCP project used to achieve its goal and objectives.

1. PROJECT BACKGROUND

1.1 Introduction

Nepal is one of the poorest countries in the world with an annual per capita income of approximately $240 per year and 42% of the population is estimated to be living in poverty. The population growth rate is high at 2.27 % per year and the total fertility rate of 4.1 still remains one of the highest in the world. At the current rate, over the next 20 years the current population of approximately 23 million people is projected to increase by about 60%[1] which will put additional pressure on the existing system. Though some progress has been made in the area of family planning in the past few years, there is still a wide gap between contraceptive knowledge and practice. The Nepal Demographic and Health Survey (NDHS), 2001 shows that though knowledge of at least one family planning method is nearly universal (99%) among Nepalese men and women, use of contraception remains relatively low. The Contraceptive Prevalence Rate (CPR) among currently married Nepalese women is 39%. The NDHS 2001 also recognizes a gap between urban and rural i.e., CPR for urban Currently Married Women of Reproductive Age (CMWRA) is 62.2%, whereas CPR for rural CMWRA is almost half the urban average at 36.9%.

In spite of the marked increase in the use of contraceptives in Nepal, unmet need for family planning services is still high. Twenty-eight percent (28%) of the currently married women in Nepal have an unmet need for family planning services, of which 16% have a need for spacing and 16% have a need for limiting. If the unmet need of the women for family planning were fulfilled, the current contraceptive prevalence rate would rise from 39% to 67 %. If currently married women who say that they do not want any more children or that they want to wait for two or more years before having another child, but are not using contraception are defined as having unmet need for family planning. Unmet need for family planning is mostly found among the poor and marginalized communities of Nepal. The barriers to the poor and marginalized accessing services include rumors and misconceptions as well as equity issues related to gender, age, caste, ethnic group, income and distance from health services and associated transport costs.

With a view to fulfill the reproductive health intentions of disadvantaged and marginalized communities, the Health Communication Partnership (HCP) Nepal, Flexible Funds Project was formally launched in October, 2003. Locally known in Nepali as **'Sadbyawahar Swastha Pariwar' (Valued Behavior for Healthy Family)**, the aim of the project was to reach the poor and marginalized communities with quality reproductive health information and services and assist them in achieving their reproductive intentions. The HCP project was implemented by the Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs with SC/US, through its NGO networks and in collaboration with USAID's major bilateral program, the Nepal Family Health Program (NFHP) and the Nepal Government. In particular, HCP linked with NFHP's project areas to extend FP/RH services beyond the periphery of NFHP's mandate to reach out to the marginalized population. The project area was four selected districts, namely Sunsari, Siraha, Dhanusha and Banke.

The ***'Sadbyawahar Swastha Pariwar'*** project addressed social inclusion through increasing access and equity to family planning and reproductive health services by disadvantaged and marginalized persons in rural areas. The project has helped women and couples from disadvantaged group achieve their reproductive health intentions through strengthening the delivery of quality services to the periphery of the health system, linking potential clients with service providers in a way that addresses service related cultural barriers, increasing informed choice and utilization of Family Planning/Reproductive Health FP/RH services and strengthening the capacity of the NGOs in improving service quality of public sector and linking health services with the community.

The disadvantaged and marginalized communities were selected as participants in response to the objectives of the Government's Second Long Term Health Plan 1997-2017 to "*improve the health status of the population particularly those whose health needs often are not met: the most vulnerable groups,*

[1] Health Sector Strategy: An Agenda for Reform. Ministry of Health and Population, October 2004 p. vii

women and children, the rural population, the poor, the underprivileged and the marginalized population." Addressing social inclusion is a priority of the Nepal Government. The Tenth Five Year Plan (2002-2007) and Nepal's Poverty Reduction Strategy include social inclusion as one of their four pillars. The Health Sector Reform Strategy draws on the Second long Term Health Plan and Poverty Reduction Strategy and articulates its aim to address social inclusion in health through the Nepal Health Sector Program-Implementation Plan (NHSP-IP) 2003 -2007. The NHSP-IP states *"Ensure access by the poor and vulnerable to essential health care services (EHSC) –increase the coverage and raise the quality of essential health care services with special emphasis on improved access for poor and vulnerable groups".* Even though social inclusion has been a government strategic focus, actual implementation has been a challenge and this project provides a model for social inclusion for replication by the government and other partners.

Among those who are regarded as *vulnerable* groups are the most socially excluded: the Dalits (untouchables) and occupational castes in the Hindu caste system, the Janajatis and the non-Hindus (Muslims). A significant proportion of the total population of Nepal are Dalits and indigenous people, yet Dalits in particular continue to have the lowest indicators as compared to the national average. The NFHP Mid Term Household Survey 2005 (see table 1), shows that CPR for Dalit is lower than the higher castes (Brahmin and Chettri). Data also shows that the CPR for Muslims in NFHP's 17 Core Program Districts is significantly lower than the National average CPR of 39% (NDHS 2001) as well as other castes, including Dalits.

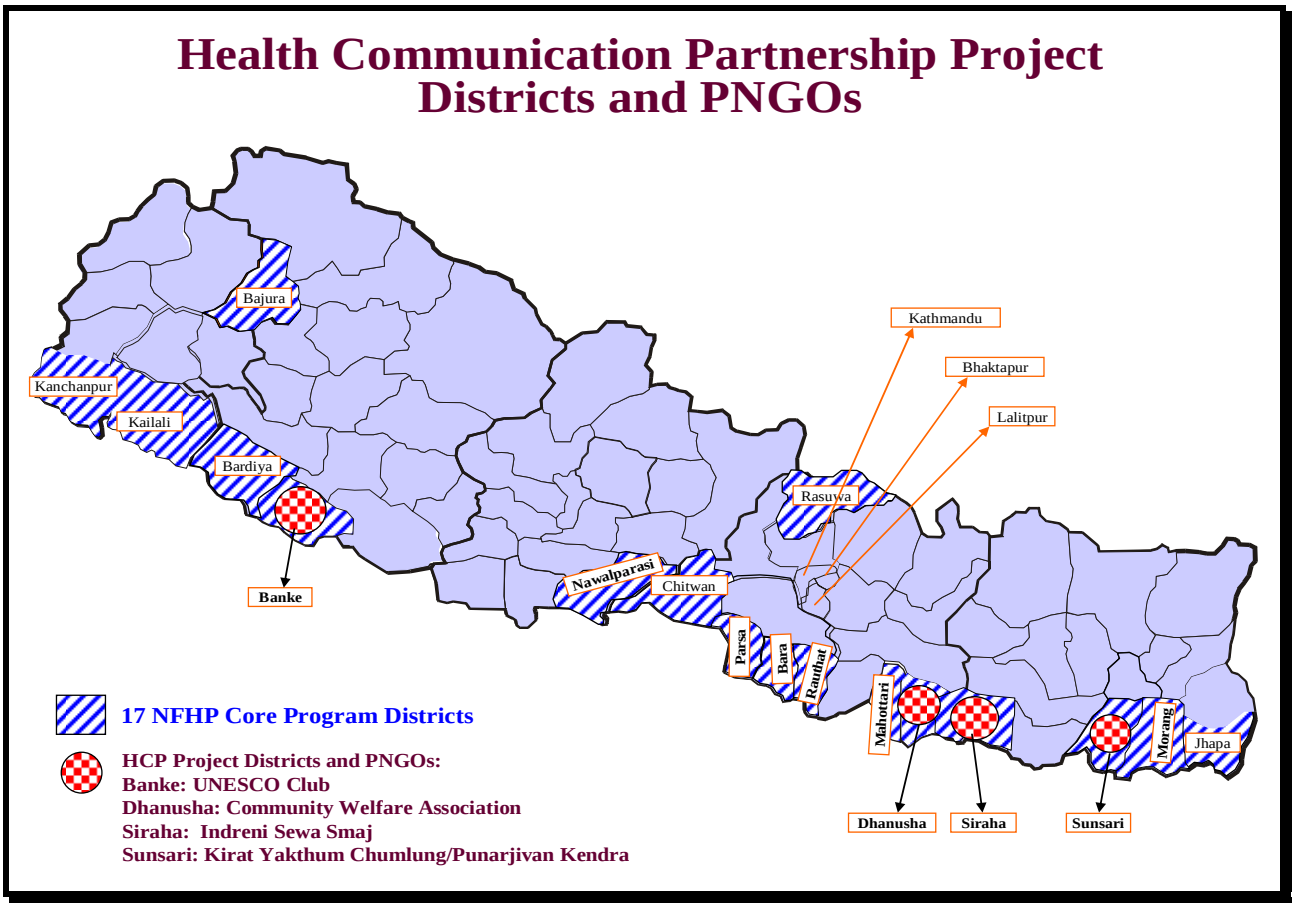
Table 1: Contraceptive Prevalence Rate (CPR) in NFHP Core Program Districts by Ethnicity

Caste/Ethnicity/Religion in CPDs	Any Modern Method
Brahmin/Chhetri	44.6
Tibeto-Burmen	49.7
Tharu	63.5
Dalit	**40.4**
Muslim	**14.0**
Other Terai Origin	44.4
Others	36.6

Source: *NFHP Mid – Term Survey 2005*

Within the four districts, the 52 Village Development Committees (VDCs) were selected based on the following criteria:

- High proportion of poor and marginalized population (Dalit and Muslims)
- Low Contraceptive Prevalence Rate and high unmet need
- Existence of NGOs working with PVO partners
- Availability of family planning services including IUD/Norplant
- Districts with an NFHP presence



Capacity building of NGO partners was an important project strategy. It was recognized that NGOs could play a critical role in ameliorating inequities and social exclusion, supporting the government to extend health services to disadvantaged and marginalized and in linking underserved communities to health facilities. Capacity building opportunities for NGO partners were geared towards bringing sustainable impact in the community, namely: Strategic Health Communication and Advocacy Workshop, Training of Trainers to NGO and District Health Office staff on PLA/RLG, Training of Facilitators and Supervisors on PLA/RLG Implementation, Lot Quality Assurance Survey Training, PDQ Training, FP Counseling Training, Developing Leaner Generated Materials workshop, and a Planning Designing Monitoring and Evaluation workshop.

This report presents HCP's activities and accomplishments made during the three years of the project from October 2003 to September 2006.

1.2 Intermediate Results:

1. Increased knowledge and interest in FP services through NGO involvement in FP programs
2. Improved quality of FP service delivery by health providers at the facility, community and local levels
3. Increased access of communities to FP services
4. Improved social and policy environment for FP services and behaviors

For each of the four results above, the approach is detailed by a narrative with a presentation of the accomplishments, success stories, challenges and modifications to the project. The narrative is supplemented with tables and graphs.

2. STRATEGIES AND INTERVENTIONS

2.1 Increased Knowledge and Interest in Family Planning Services through NGO Involvement in FP Programs

Approach

Tailored Behavior Change Interventions

In order to increase community knowledge and interest in FP and to address the major obstacles to the achievement of reproductive health among the marginalized populations, it was critical to address the specific issues of each population and tailor the BCC activities to fit their needs. Before the program started, it was found that the intended audiences were interested in both improving their health and in literacy. Some of the barriers to service identified were perceived religious prohibitions, rumors and misconceptions, other culturally specific issues.

Focus group discussions were conducted in four districts with marginalized women and decision makers (mothers-in-law, fathers-in-law and gatekeepers) to determine the prevailing rumors on FP. The key rumors and misconceptions found were as follows:

- Temporary contraceptives, particularly pills and Depo Provera, made women weak and caused heavy bleeding, interruption of the menstrual cycle, headache, swelling, and life time infertility
- Condoms burst, and create discomfort to the wife and decreases satisfaction of the husband.
- IUCD and Norplant both cause infection. IUCD moves around the body.
- The majority of women believed that vasectomy weakens men so they prefer to have mini-lap. However, husbands believed that if their wives had mini-lap, then this would encourage them to be unfaithful.
- Muslim community believed that the Quran prohibits the use of FP.
- Some health workers fail to provide proper counseling, were impolite and rude, demanded money for contraceptive methods, and limited the clients access to all FP methods.
- VSC failed.
- Preferred more children, especially boys.

Localized Radio Health Program and Support Materials

In order to reach intended marginalized and Muslim audience with consistent and culturally appropriate health information, an existing successful entertainment- education Drama Serial **'Gyan Nai Shakti Ho' (Knowledge is Power)** on family planning and reproductive health topics produced by Ministry of Health and Population with technical assistance from Nepal Family Health Program was adapted and localized in two languages (Maithali and Awadhi).

The localized adaptation was specifically tailored to the needs and culture of the marginalized communities. It was adapted by local writers to feature familiar characters, places and a story line that was relevant and culturally appropriate to the communities. As a result the radio program received an overwhelming response from the disadvantaged and marginalized populations in the selected districts. An additional output of the localized versions was the pride and recognition expressed by communities in having a health drama serial in their own languages which led to wide and regular listenership. For the Muslims in Banke district, who are mostly Awadhi speaking, it is the first radio health program in their language. Interestingly, there was also a positive response from communities in Indian border towns who tuned into the program.

"The radio health program has given an appropriate forum to the Muslim women to discuss on reproductive health issues of their families and communities. This type of program was the first ever to be introduced with main focus on the Muslim community." - Maulana Abdul Zabbar Manjari, Muslim Religious Leader, Banke

Similarly support materials developed for drama serial message reinforcement were adapted taking local context and intended audience into consideration. The materials were adapted using local translators as well as the Leaner-Generated Material Approach for the comic book for low literate and with an emphasis on characters and settings from the local culture.

Collaboration with District Health/Public Health Office:

In close collaboration with District Public Health Office (DPHO), the '***Gyan Nai Shakti Ho'*** radio program was reviewed by a team of content specialists and produced by a local production house. The drama serial was broadcast under the auspices of the DPHO as a Ministry of Health and Population radio program, and contained summary-style programs which included interviews with leading government health staff as well as community influentials and project beneficiaries. Due to the highly collaborative effort and leadership by the DPHO, the new media law which restricts the broadcast by FM stations did not impact the airing of the drama serial.

The localized version of drama serial ***"Gyan Nai Shakti Ho"*** was launched from January 1, 2005 from two popular FM stations: Image FM which broadcasts in Sunsari, Dhanusha and Siraha districts, and Radio Bageshwori FM which broadcasts in Banke. DPHOs and peripheral health facility staff, distributed radios and support materials (comic books, posters, attendance registers and facilitator guidelines) in the program areas.

Participatory Learning and Action/Radio Listeners Groups (PLA/RLGs):

Facilitated radio program listening and discussion was integrated into non formal literacy courses, known as Participatory Learning in Action/Radio Listeners Groups. Combining these two different methods had a synergistic effect of attracting and interesting participants as well as providing an appropriate forum for facilitated discussion about the more sensitive family planning and reproductive health issues. Also, the local classes could be supported by the entertaining, technically correct radio program that their families at home could also listen to, thereby expanding program impact and creating an enabling environment for change.

Community Based Facilitators were selected on the basis of being a literate Female Community Health Volunteer (FCHV) or, if not available, a woman who could work with the FCHVs and the local health facility staff. The ability to speak both the national language of Nepali as well as the local language was required. 374 facilitators were trained to provide literacy instruction as well as to facilitate radio listening sessions. Out of the 374 (3 male and 371 females), 34% of facilitators were from marginalized populations. They also performed a vital role in linking women interested in FP with the health facilities, reinforcing the FP messages and providing a supportive, enabling environment for change. A cadre of 45 community mobilizers (19 male & 26 female) were selected to assist the facilitators and to supervise and monitor the PLA/RLG. Thirty-three percent of the mobilizers were from Dalit and Muslim communities.

Considering the time and economic constraints of the participants, special care was taken to ensure that they decided the timing of the meetings so that it would be convenient for them. The PLA/RLG Centers were organized two hours per day. The group met six times a week, four times for literacy instructions, one time for radio listening/discussion and one time for both literacy instruction and radio listening/ discussion. After the completion of seven months course many of the participants requested further activities to reinforce their knowledge, so post PLA/RLG Centers were operated once in a week to listen to the national broadcast of drama serial and discuss issues. In addition to the almost 10,000 women who directly benefited from the PLA/RLG centers, many family members and friends listened to the radio programs and discussed the classes and issues, thereby creating a more enabling environment for change.

The FP messages were reinforced through multiple channels for a synergistic impact. The messages in the radio drama serial (mass media) were reinforced and discussed in the PLA/RLG classes (interpersonal communication) which helped and supported the participants in creating action plans for behavior change both individually and to diffuse the messages to the larger community. PLA/RLG participants were promoting the radio program and disseminating messages to the broader community and thereby strengthening an enabling environment for change. For example, husbands who are highly mobile workers (rickshaw pullers, vegetable and fruit vendors) listened to the radio program while working.

A total of 374 PLA/RLG centers were established in 58 VDCS of the 4 project districts in two phases covering 9,321 beneficiaries, primarily married women of reproductive age from Dalit and Muslim communities **(see Table 2).** Participants were selected from among the disadvantaged and marginalized communities particularly those with unmet need for family planning. The total percent of marginalized participants in PLA/RLG centers was more than 94%.

Table 2: PLA/RLG Centers by District and their Ethnic Composition (F/Y 2004-2006)

Districts	# of PLA/RLG Centers	No of Participants				
		Caste Division		Total Dalit & Muslim	Other	Total Participants
		Muslim	Dalit			
Siraha	96	437	1873	2310 (95%)	121	2431
Dhanusha	78	365	1529	1894 (94%)	128	2022
Sunsari	88	821	1337	2158 (96%)	95	2253
Banke	112	987	1419	2406 (92%)	209	2615
Total	**374**	**2610**	**6158**	**8768 (94%)**	**553**	**9321**

Note: Dalit includes, Chamar, Mushahar, Khatway, Dom, Paswan etc.

The median age of marriage for women in Nepal is 16.6 years and median age for first birth is 20 years.[2] Priority for selection of participants was given to those married women who already had one or two children and wished to space or limit their next birth and to those who were recently married. Consequently, the highest proportion of participants was between the ages of 25-29 years of age (26.9%) following by the 20-24 years age group (24.1%).

Table 3: Age Group of Participants by Project Districts

Age Group	Name of the Districts				
	Dhanusha	Siraha	Banke	Sunsari	Total
15-19 Years	326	613	185	285	1409
20-24 Years	476	593	644	541	2254
25-29 Years	477	572	697	765	2511
30-34 Years	372	344	513	297	1526
35-39 Years	224	184	376	234	1018
40-44 Years	105	103	160	100	468
45 Years Over	42	22	40	31	135
Total	**2022**	**2431**	**2615**	**2253**	**9321**

Following live listening of the drama serial and discussion on the topic, each PLA/RLG Center developed an action plan for disseminating the messages in the communities and to identify ways to assist others who were voluntarily interested in FP to seek services. As part of the action plans, participants went out into the

[2] NDHS 2001

community and collected the names of women who were voluntarily interested in adopting FP methods and RH services.

In coordination with DPHOs, health professionals clarified the misconceptions and rumors with facilitators, supervisors and PNGO staff. Health facility staff visited the PLA/RLG centers several times to discuss the rumors with the participants and to disseminate the correct information.

A key factor in program success was consensus with communities from the beginning in order to garner a high level of participation and involvement in the project and thereby ensure a smooth implementation and ownership for the project activities. This step proved especially vital during the conflict situation where tensions and restricted mobility had the potential to disrupt activities. Orientations at the Village Development Committee (VDC), the grass roots administrative level, were conducted in the project sites among community influentials. The objective of the orientations was to identify participants with most unmet need, facilitators of the PLA/RLG centers from the local community, and establish the Center Management Committees (CMC). The CMCs were responsible for the logistical arrangements (seating place, shelter, maintenance of radio, participation etc.) and solved any concerns that affected the operation of the centers.

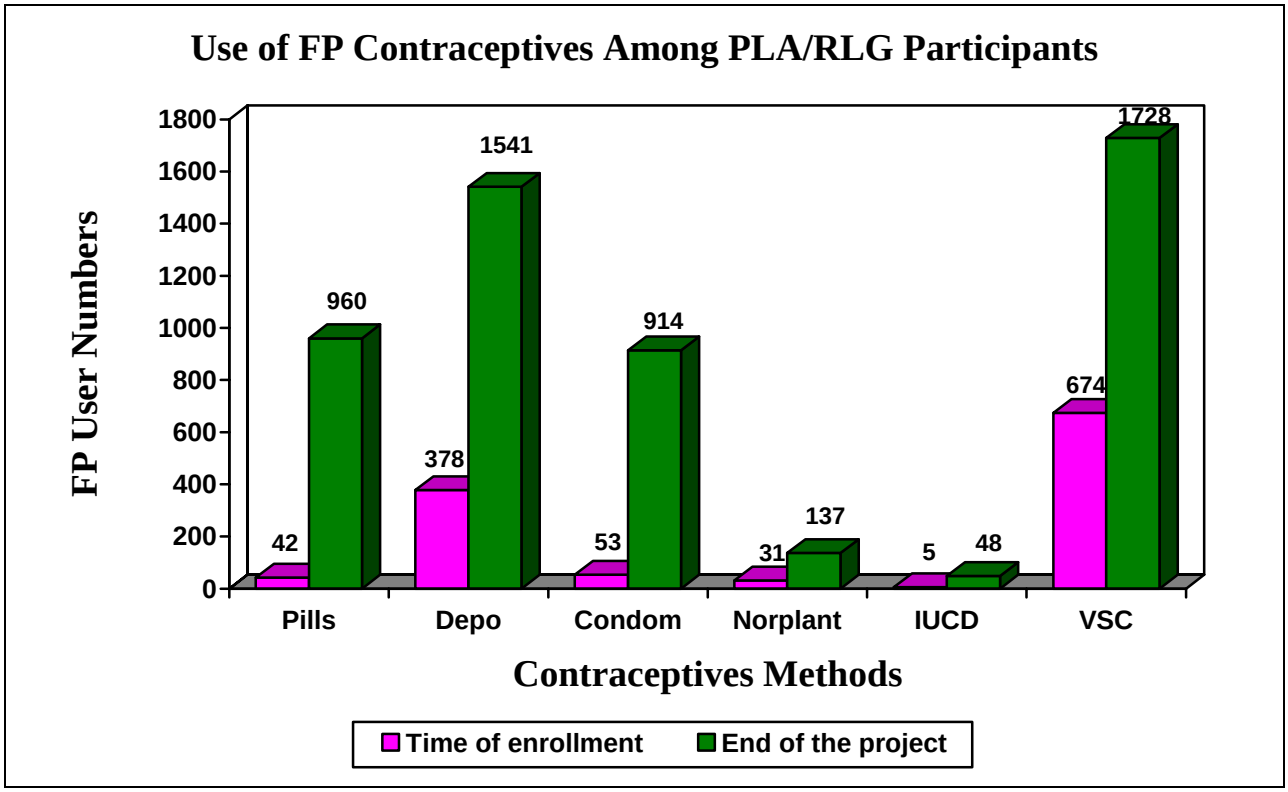
Accomplishments

The local interest in the PLA/RLG centers was more than expected and whereas the original plan called for 6000 participants, the project adapted to be able to reach out to 9,321 interested participants. Out of the total 9,321 participants, 7,769 (83%) were eligible for FP services. The PLA/RLG proved to be very effective in reaching the poor and marginalized population with health messages and influence behavior change. The percentage of FP use among PLA/RLG participants increased substantially from 17 percent at the time of enrollment in June 2004 to 68.45% at the end of the project in September 2006, a total increase of 52 percent.

Table 4: Use of FP by PLA/RLG participants by district at the time of enrollment (November 2004) and by the end of the project (September 2006)

Contraceptive Devices	Banke		Sunsari		Siraha		Dhanusha		Total	
	Before	End of project	Before	End of project	Before	End of project	Before	End of project	Before	End of project
Pills	14	274	1	375	14	219	13	92	42	960
Depo	145	465	111	487	16	328	106	261	378	1541
Condom	41	476	5	183	3	153	4	102	53	914
Norplant	19	12	2	75	1	11	9	39	31	137
IUCD	4	22	1	11	0	8	0	7	5	48
Sterilization	47	572	119	158	220	384	288	614	674	1728
Total	**270**	**1821**	**239**	**1289**	**254**	**1103**	**420**	**1115**	**1183**	**5328**

Figure 1: Use of FP by PLA/RLG participants during the time of enrollment (November 2004) and by the end of the project (September 2006) in total



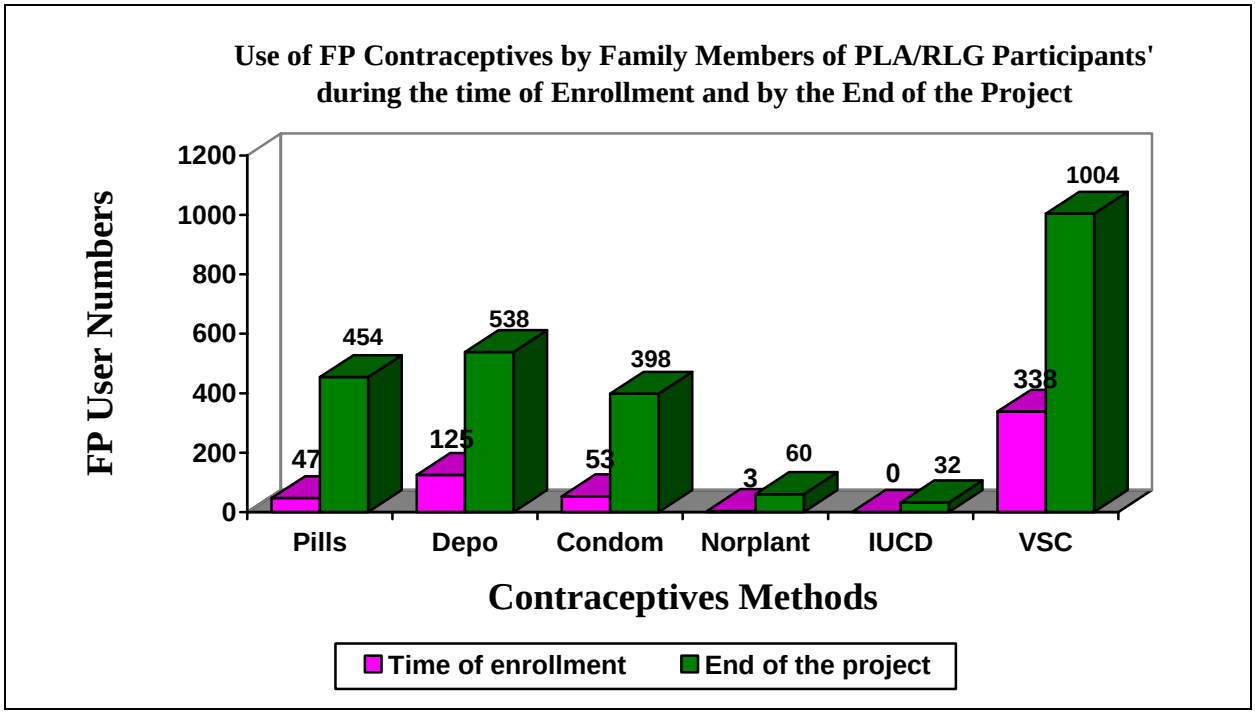
Likewise, family members of PLA/RLG were also found influenced in using family planning methods as a result of PLA/RLG which raised from 16% at the time of enrollment to 70% by the end of project in September 30, 2006, a 54% increase from among 3,539 eligible couples. **(See Table 5 and Figure 2)**.

Table 5: Use of FP by family members of PLA/RLG participants during the time of enrollment and by the end of the project

Contraceptive devices	Banke		Sunsari		Siraha		Dhanusha		Total	
	Before	End of project	Before	End of project	Before	End of project	Before	End of project	Before	End of project
Pills	14	116	12	66	12	180	9	92	47	454
Depo	21	120	5	21	46	218	53	179	125	538
Condom	6	93	20	54	8	140	19	111	53	398
Norplant	1	14	0	3	0	15	2	28	3	60
IUCD	0	5	0	6	0	9	0	12	0	32
Sterilization	4	22	26	79	124	383	184	520	338	1,004
Total	**46**	**370**	**63**	**229**	**190**	**945**	**267**	**942**	**566**	**2,486**

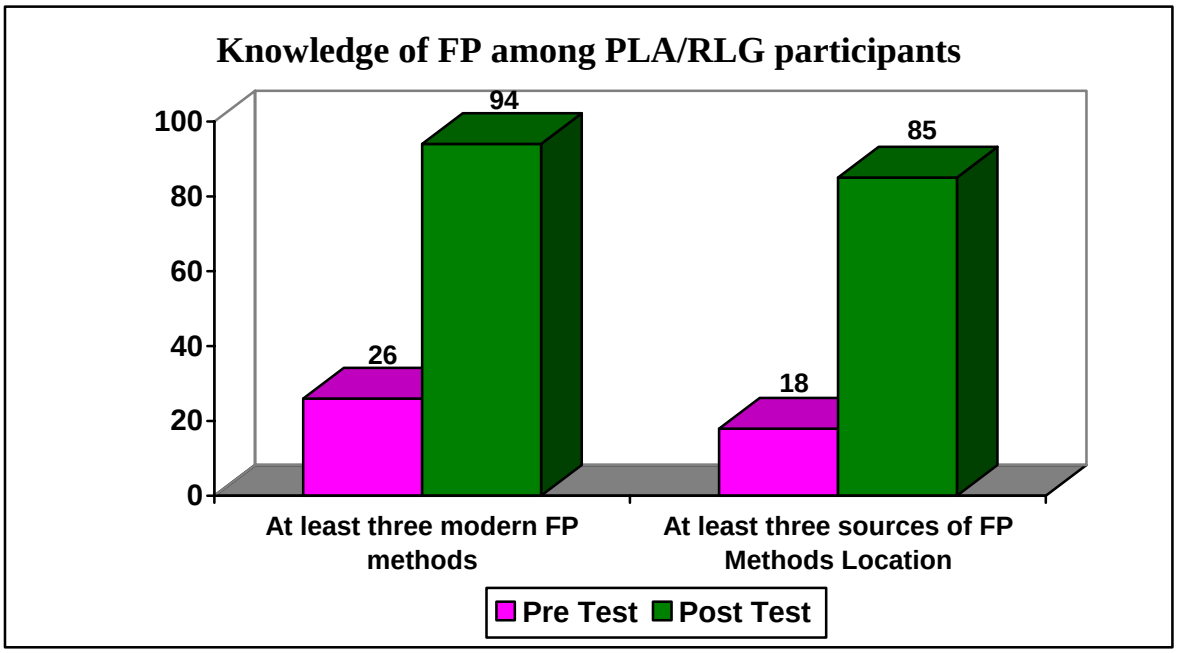
Source: *HCP Project Monitoring Data*

Figure 2: Use of FP by family members of PLA/RLG participants during the time of enrollment and by the end of the project



A pre and post test was conducted among the participants at time of commencement and completion of PLA/RLG Centers to assess FP knowledge levels. Thirty-four per cent (34%) of participants were selected randomly from the each PLA/RLG center for the pre and post test. The proportion of participants who could mention at least three modern FP methods increased almost three times from the pre test level from 26 to 94 per cent. A similar rate of increase was found among participants who were able to name at least three sources to obtain FP/VSC services from 18 to 85 per cent at post test.

Figure 3: Knowledge of Family Planning among PLA/RLG participants



A literacy test was conducted at the end of the 7 month course and 95 per cent of the participants gave their examinations. Among them almost 99 per cent obtained a score indicating that they could read and write simple words and sentences like their names and FP messages.

The PLA/RLG study conducted among in 2006 among 1,679 respondents (839 PLA/RLG members and 420 from non PLA/RLG and control areas) revealed that the percentage of respondents who were currently using any method of FP was significantly higher among PLA/RLG members (44.8 per cent) than those of non-PLA/RLG members and respondents of control areas (36.9 per cent). The survey results further indicated the program had also been instrumental in increasing the ability of women in different aspects of life as a result of their participation in PLA/RLG. For instance, over 85% of the respondents acknowledged that they became able to use family planning; another 76% said that they became able to talk freely in front of the group while the other 62% respectively claimed that they were able to read and write as a result of their participation in PLA/RLG. Discussion on family planning issues between husband and wife is an internationally recognized proxy for increased ability to adopt FP, spousal discussion in the project area was found to be significantly higher among PLA/RLG members and non members than those from control areas. Similarly, a higher percentage (33%) of the PLA/RLG members than non-members (24%) reported having talked about family planning with a health care provider. A great majority of the PLA/RLG members (84%) reported that they have shared their enhanced health knowledge with their friends, neighbor and community people.

The significant results achieved in a relatively short period of implementation were due to the focused interventions in project sites, strong community participation and ownership, prioritizing those with most unmet need, reinforcing messages through both mass media and interpersonal communication, addressing myths and misconceptions, linking literacy and communication, linking demand creation activities with the implementation of Partner Defined Quality in local HFs to improve services, and supporting the extension of FP services to disadvantaged and marginalized. Policy, advocacy and mobilization of religious leaders were also important for project success.

SUCCESS STORIES FROM THE FIELD

"Unforgettable Moment of My Life"

In the month of November a few people with new faces came into our village. They talked with some influential people of our community and informed them that their organization was going to start a PLA/RLG Center in our village. I also heard that thing and told my husband that evening about my interest. My husband is a Rickshaw puller and he told me ***"if the other women of our VDC will go there, you can join the Center"****.*

This is the story of my participation at the PLA/RLG center. I am Kitaboon Nisha, a Muslim women age 26 having 2 sons and 1 daughter. The spacing between my children is not more than 17 months. I always thought that I wouldn't have more than three children because I have lot of responsibility everyday. My husband departs from house for his regular job. I wanted to learn how I could avoid pregnancy. Sometimes I talked about this with my husband but every time he got angry with me saying that this is was against our religion and never to raise this type of issues with him.

But the day came. I regularly participated in the PLA/RLG Center. In that Center, I learned a lot of things regarding our family health especially about family planning. I was so happy when I heard the same message of family planning through radio drama serial ***"Gyanay Shakti Hoy"****. I again requested my husband about my intention to adopt family planning method from the nearest health facility center, but he again refused my request. One day my husband came home a little early from his work and he got the opportunity to listen to the radio drama serial. That day, my husband realized that this program was very important for us and since every Wednesday he started to listen to the radio program. After a few weeks he met with our facilitator and discussed about the radio program and messages delivered through drama serial. The day after that he told me that we should visit health facility center and later we went there. After receiving counseling services from MCHW, we decided to use Depo Provera for six months and then go for permanent family planning method in the winter. Now I am very happy with my family and can't forget the radio drama serial which brought happiness in my life. Now I am advocating with my other friends to listen to the radio health program and adopt health service, as per their need.*

"Radio Drama Serial was Turning Point in My Life"

I am a 17 years old and I live in Ghodghas VDC ward no. 2 of Dhanusha district. There are 16 people in my family including my mother, father, uncle, aunt and six sisters. My three elder sisters were married in age between 12 and 13. No one in my family is literate. My father is a musician associated with one band. Due to our big family and low income, my father never tried to send us to school. I am helping my mother with household work. I was very interested to learn to read and write. My friends are going school but I was afraid to express my intention.

Last November the CFWA started a PLA/RLG class in our village and I requested my mother to join the class because there was no fee to join the class. That class was only for poor and marginalized people of our community. I am also from a marginalized caste so I was eligible for the class. As it was free, my mother gave permission to join the class. After seven months in the class I have learned so many things. Now I can read and write. During the PLA/RLG sessions, I heard the 52 episode of drama serial which was very useful for us. From drama serial, I learnt that the appropriate age for marriage is 20 years. In the PLA/RLG period, one day my father told me to get ready for marriage. I tried to convince my parents that I am too young for marriage as I had learned from radio drama serial but they did not accepted my request.

After few days I shared this with my RLG center friends and they were surprised. They decided to try to convince my parents. Almost all participants of the RLG met my parents and convinced them about disadvantage of early marriage and after that my parents agreed on that. Now I am 18 and participating in the post PLA/RLG sessions and decided to marry only after being I turn 20 years old. I really want to say thanks to the radio health program and our friends who saved my life.

"Radio Drama Serial influenced to Change Behavior"

I am a 32 year old Muslim women. My name is Rubeda Khatoon and I live in Haripur VDC of Sunsari district. My husband has his own tailoring house. We have 2 sons and 2 daughters. My husband wanted to make me literate but due to religious barriers, regular house work and care to children. I was unable to join PLA/RLG class. But after one year, the new PLA/RLG center was introduced in our village. My husband several times heard that these classes were for marginalized illiterate people and providing health message. He asked me to join the class.

During the class, I heard the radio drama serial ***"Gyane Shakti Hai"*** (Knowledge is Power) in our local language. From the radio drama serial I learnt about family planning contraceptives and discussed with my husband about its advantages. One day, we decided to go to district hospital for permanent method of FP but our respected family members particularly my father and mother in law rejected our interest. Similarly our neighbors told that maybe I would die after the operation. They also showed fear that our family would also be rejected by community.

There were lots of cultural barriers to adopting family planning for us, but finally we thought that our family health was more important than others. I went for minilap at the district hospital. Seven days after the minilap operation I was feeling better and I could do all household work. Now I am also involved in other income generating activities, previously I did not have sufficient time for that. It increased our income source. Our children are going to school for formal education and we have sufficient income source for their further education. We strongly believed that we did not go against ISLAM and QURAN. In the Quran it is written that we should not speak lie but people do not take care of those things.

Similarly, it does not mention anything about family planning as such we do not think that we have gone against our religion. Now we are advocating about family planning to other members of PLA/RLG as well as to other friends. Some of them had recently taken VSC service and some of them are using temporary family planning devices. I can say the localized version of Maithali drama serial helped us to change behavior.

"We are the ROLE MODEL Mother-in-Law and Daughter-in-Law of our Community"

Now our community people are saying that these two women are role models for our community. My name is Indira Devi Sada living at Khajuri VDC of Dhanusha district. There are eight family members in our family including my father and mother in law, one son and one daughter. My husband is in an Arabian country to earn money. In the year 2004, my all friends joined the PLA/RLG class and I told my mother in law about my interest to join the class. But she told me that ***"How would you join the class as you have lot of things to do at home".*** I was worried when she rejected my interest. From November 2004, she herself joined the class for seven months. Every day she was talking with me about what she learned from the class and messages she heard from the radio drama serial.

After one year once again the new classes started in my village and this time my mother in law registered my name for the PLA/RLG class. I was so happy and also surprised how my mother in law's behavior got changed. My mother in law expressed that *"since my son has gone out of the country to earn money* ***it is our responsibility to provide better opportunity to his wife so that she can take care of her children, so I enrolled my daughter-in-law in PLA/RLG class."*** I was so excited to join the class. During the class period, we listened to the radio drama serial which provided information about the advantages of FP contraceptives, side effects and its effectiveness to avoid unwanted pregnancy. The message given through radio drama serial was entertaining and in our mother tongue. I feel that now I can decide which method I should adopt when my husband comes back from his work.

In March 2006, my husband came back and after communicating with him what I learnt from PLA/RLG classes, we decided to take Depo Provera and immediately visited sub health post. Now, I am so happy because I can read and write as well as avoid pregnancy. The villagers are saying that we are role models of our community. My mother-in-law and I are involved in educating people about family planning and requesting them to listen radio drama serial and also join the PLA/RLG classes.

Challenges

Regular attendance: The trend of monthly attendance by the participants of the PLA/RLG centers varied according to the agricultural cycle as they are largely poor farm laborers. During the harvest, the absence of participants increased. It was found in some groups that the attendance of the radio listening sessions was slightly lower than the attendance of the literacy Centers. The reason is likely to be that although literacy Centers were conducted on a flexible schedule according to the convenience of the participants, the radio listening was fixed according to the time of the broadcast. This could be rectified in future projects by adding on cassette players so that the radio listening sessions can be conducted at times convenient to the participants.

Cultural barriers: A PLA/RLG center located in a Muslim community in Sunsari was stopped for five days by the community when the facilitator discussed about family planning which they thought was against their religion. The partner NGO resolved this problem by holding a meeting with community influentials including Maulana (religious leader) where it was agreed that the Center could restart provided that the Center would not discuss FP. After a few classes had been conducted in this way, the NGO again requested the Maulana to permit the discussion of FP methods. The Maulana hesitated but he eventually agreed to allow the sharing of FP information with the participants on the condition that the facilitator was not allowed to convince women to use FP services. The facilitator began sharing information on FP methods, their advantages and availability of services. As a result the participants initiated discussions with their husbands and family on adopting FP and began to access FP services. Confidentiality was carefully maintained to protect the client's rights.

Meeting with the Maulanas (Muslim religious leaders) in Banke district

The meeting with the Maulanas (Muslim religious leaders) were a major activity in Banke and Sunsari to create an enabling environment for FP discussion and adoption FP in their communities. The objective of the orientation was to share information about the project, its objectives and address issues and concerns related to Islam's view on FP use so that the Muslim communities and religious leaders would be more open to the aims of the project.

In Banke district Maulanas reviewed the Islamic Dharma Granth Quran (Religious book) to find if there were any religious prohibitions against accepting FP methods. They discovered that there were no such prohibitions. As a result, the Maulanas agreed to allow FP use among Muslims in their communities in Banke. Through the summary program of ***Gyanya Shakti Hoy***, Maulanas encouraged the adoption of family planning for better maternal and child health.

2.2 Improved Quality of FP Service Delivery by Health Providers at the selected Facility, Community and Local Levels

Approach

Partners Defined Quality

Access to quality Family Planning/Reproductive Health (FP/RH) services is fundamental to every citizen's right to good health. However, equity and access to quality FP/RH services by marginalized populations has been severely disregarded in Nepal for multiple reasons including mistrust between clients and service providers. In order to address specific constraints experienced by the marginalized communities and to bridge the gap between the health providers and clients, the Partnership Defined Quality (PDQ) approach was applied.

PDQ aimed to increase ownership and involvement of the community in running their local health facility and thereby improve and strengthen utilization of services. It is right based approach which helps to fulfill the right of the community in accessing and improving quality of health services. PDQ is a process which ensures involvement of people from different segments, from elites to marginalized communities, in identifying, planning, implementing, monitoring and evaluating programs at the community level and thus providing an opportunity for community empowerment. It particularly emphasizes on the inclusion of disadvantaged population in the entire process.

The PDQ process included a one day orientation and group discussion with periphery level health facility staff, primarily with the objective of determining the health facility staff's understanding of quality services. Similarly, on the second and third days, focus group discussions were held with community members especially with marginalized male groups, mothers-in-law and daughters-in-law groups to understand their perspective of quality health services. On the fourth day an analysis of the group discussion was conducted and on the fifth day a 'Bridging the Gap' workshop was organized.

Bridging the gap workshop at a glance

During the **"Bridging the Gap"** workshop, community members and HF staff prioritized the issues identified during the group discussions and prepared an Action Plan to resolve the problems and constraints. A Quality Improvement Team (QIT), which included Health Facility Operation and Management Committee (HFOMC) members and four Dalit/Muslim representatives were formed in every project site to take the Action Plan forward. The responsibility of the QIT was to find solutions with HF/district staff and identify funding (either public or private) if required. Issues that could not be rectified at the community level were brought to the District Public Health Offices through the district Reproductive Health Coordinating Committee (RHCC) and funds were sourced from the district Quality Assurance Working Groups (QAWG).

Accomplishments

PDQ processes were implemented in all 58 VDCs of the project area and out of these 30 PDQ were implemented under the HCP project. The rest of the PDQ activities were conducted under the NFHP project. The PDQ identified a wide range of recommendations which varied between health facilities.

Major problems identified jointly by the community and health workers included the following:

1. **Lack of necessary supplies, equipment and medicines**
2. **Lack of physical facilities** (such as no provision of toilet and water facility, no separate room for FP counseling, ANC, PNC and FP services, no proper waste disposal system, no laboratory services)
3. **Irregularity in service delivery:** no regular and fixed time for clinic operation. Health workers not working full time.
4. **Unavailability of all family planning services**
5. **Absence of staff :** Absence of HWs, trained female staff for providing FP/MCH services
6. **Lack of community awareness on health programs and activities**
7. **Lack of good Client – Provider Interactions** and discrimination in providing services to the poor and marginalized population by health workers.

The PDQ process changed community perceptions and community members started mobilizing local resources to address the health facility related quality problems. Community members also started to demand regular and timely health services from the health facilities and outreach clinics. Some examples of achievements made as a result of PDQ process were:

Udayapur Sub Health Post (SHP), Banke: There was no separate room for pregnancy check ups and FP services in SHP at **Udayapur, Banke.** With initiation from Health Facility Operation Management Committee and VDC and in **coordination with PLAN Nepal,** a separate building was constructed for the SHP which included a separate room for FP/MCH services. The same achievements were made at Mahuwas SHP, Dhanusha and Laxmipur SHP, Siraha.

Jalpapur SHP, Sunsari lacked a weighing machine and bag for weighing babies. The equipment was supplied to the health facility by the DHO in coordination with the district Quality Assurance Working Group.

Manikapur SHP, Banke: While the MCHW of Manikapur SHP went for a midwifery course, the center was unable to provide ANC/PNC and FP services to the clients. However, with initiation of HFOMC, an AMN staff was hired locally to replace the MCHW's vacant position, thus enabling clients to receive FP/MCH services. The budget for the position was provided through Village Development Committee Fund.

Khajurakhudra SHP, Banke did not have its own building. However, with initiation from the HFOMC and QI group, Plan Nepal funded the SHP to build its own building. The construction of the building is almost complete.

Madar SHP, Siraha did not have a separate room for counseling, a toilet nor safe drinking water, to address this problem, the HFOMC and QI group conducted a meeting with VDC which agreed to built a pit latrine and separate room for counseling. Similarly, VDC also provided a filter to the SHP for safe drinking water.

Haripur Health Post, Sunsari's building was totally out of order. The building was cracked and had water leakage during the rainy season. With the initiation of HFMOC and QI group, the SHP mobilized local resources to maintain the building. The building was painted and services offered by the health center

were posted on the wall including the clinic operation hours. They built a fence around the SHP building to make it clean and safe. A picture of the Haripur SHP before and after the PDQ is shown below.

Before PDQ

After PDQ

The overall results showed that the PDQ process was effective in developing a better understanding between the health workers and communities towards improving the quality and accessibility of health services by the communities and making health workers more accountable towards their duties and responsibilities. The process was very effective in making local HFOMC responsible for ensuring quality services of their respective health facilities and increasing access to services by the poor and marginalized communities. The process also helped to empower the community and make them aware of their rights to access quality health services.

The major issues addressed by the HFOMC and QI Team mainly due to PDQ were management of health facility (construction and maintenance of HF building, toilet, tube well, boundry wall etc); supportive supervision and monitoring of PHCC/ORC and EPI clinics by HFOMC and QI team. It was also important to mobilize local resources to address the issues identified by PDQ on improving service quality and developing ownership among community members as they started to demand regular and quality services at health facilities.

Family Planning Counseling: In order to ensure that clients were adequately counseled on family planning before receiving services and to measure their satisfaction, client exit interviews were carried out in the project areas. A total of 340 clients exit interviews were conducted of which 53% were from marginalized population. The initial result of the clients exit interview were fed back into the program activities so that providers could fill the gaps identified by the clients. As a result, a three days training on family planning counseling and informed choice was provided to the health workers of PDQ implemented health facilities. The training was also focused on the USAID Population Policy and the importance of complying with it.

Compliance with USAID policy by the health workers was also monitored during the regular technical support visits by HCP Project staff. The final survey showed the increasing trend of clients receiving adequate FP counseling from the health care providers of PDQ sites as well as following the Population policy.

Success Story:

PDQ comes to Phulgama VDC of Dhanusha

The people of Phulgama VDC of Dhanusha district cannot believe the changes after the PDQ (Partners Defined Quality) process. As a part of HCP project the PNGO, CFWA, conducted the PDQ process in Phulgama VDC, in Dhanusha. Despite its distance from district headquarters, CFWA with the help of District Public Health Office successfully conducted the PDQ intervention.

The community people of Phulgama VDC, especially the disadvantaged and marginalized, as well as the sub health post staff participated fully. They prioritized the problems and concerns related to services provided by the SHP. A QI Team was formed comprised of VDC representatives, community people and health facilities staff. The QI Team met once a month to find solutions to the problems identified by the 'bridging the gap" activity. They shared the list of problems among VDC people, VDC, DPHO and other organizations working in Dhanusha district to solve the issues according to the prioritized order.

According to community people of Phulgama VDC, a barrier to accessing the services of the SHP was the lack of a separate room for females and males who want to tell their problems confidentially to the HF staff. With the financial support of the QA Working Group, a curtain was provided as a temporary arrangement while a more permanent solution was sought. Another priority problem was the lack of drinking water for clients at the sub health post and the lack of a latrine. The peon was bringing the water from the village, but the clients were not allowed to drink the water because it was only for health post staff. Now, with the help of the drinking water management NGO, NEWAH, one tube well and one pit latrine have been constructed at the health post. The VDC has supported the installation of electricity, furniture and fans.

The People of Phulgama VDC are also talking about changes in the behavior of health post staff. Before the PDQ process, staff never came on time to the health post. Now the staff are punctual and their behavior with patients is friendly and supportive. The Sub Health Post In-Charge is so motivated by all the positive changes, he is now exploring with other donors to support 50% of a compound wall cost. The VDC has already shown commitment to support the other half of the cost.

Because of this intervention, service utilization rate in Phulgama has increased. People now trust the services provided by the sub health post. They talk about the changes in "our health post". According to the people, health post staffs are more involved in the community activities like the PLA/RLGs and provide them with appropriate knowledge about their health concerns. The health post staffs are also building a good relationship with the community and are interacting with them to find out how they can provide better services to people.

In Phulgama VDC, PDQ has proven that by bridging the gap between the community and health post staff, positive changes can result.

2.3 Increased Access of Communities to Family Planning Services

Approach

Comprehensive Family Planning Services

Comprehensive family planning services were provided in coordination with the D(P)HO in marginalized community of impact VDCs. NGOs, PLA/RLG facilitators, FCHVs and health service providers identified voluntarily interested clients for comprehensive FP services and linked them to nearby service sites (DHO, PHCC and institutionalized FP services). The major achievement of comprehensive FP services for long-term temporary was 268 clients received Norplant and 69 received IUCD services besides VSC services.

In order to increase access, HCP worked closely with PSI to develop an innovative way to provide contraceptives in the most remote areas and to reach marginalized population in coordination with the other program activities. The operation plan for the pilot outreach was a highly collaborative effort with multiple partners: DHO, NFHP, Save the Children (US), PSI, local Health Post/Sub Health Posts and local NGOs. The project was particularly sensitive to the importance of avoiding duplication or overlapping with government health services. It was intended that this collaboration would focus on communities of disadvantaged and marginalized people who otherwise did not have access to government family planning services.

As record keeping among the marginalized was an important aspect to measure effectiveness of the program, PNGOs coordinated with the DHO to ask HF-in-charges to circulate notices to write the last name of every clients/patients clearly during registration. During the supervision visits in HFs, the DHO personnel and PNGOs staff reviewed registers to check the record of marginalized clients. Trainings focusing the importance of record keeping were provided to MCHWs/VHWs, DHO personnel and PNGOs staff. Notices to the HFs written in Nepali block letters, ***'Please write the CASTE of every client/patient clearly during registration'*** were hung on every HF.

> ***"Before the HCP program, we just used to write client's name (not his/her family name) in the registration book of health facility "****, said Mr. Amrendra Kusiyat, In-charge of Gamaharira Sub-Health Post, Siraha. He said, "****Due to this it was difficult for us to identify the caste and ethnicity of served population but with support of HCP Program t we have started recording the full name and caste of clients which has helped us to analyze the caste, age etc of served population. This has helped us to identify the needy people for appropriate health services."***

The HCP project oriented the GoN and NGO partner staff on the USAID Population policy (Tiahrt Amendment, Helms and Mexico City Policies) and enable them to comply with the policy. An one day orientation was provided to all NGO staff, board members and DPHO staff of all four project districts. The overall purpose of the orientation was to make the participants aware about the USAID Population Policy and the importance of complying with the Policy.

Expanded Voluntary Surgical contraception (VSC) services

VSC remains the most popular form of contraception in Nepal, especially among women. In addition to the services provided from static sites, the D(P)HO in each district oversees and coordinates VSC outreach services. However, due to the difficulties in transportation and low awareness of the available services, the disadvantaged and marginalized populations have limited access to those services. This has been compounded by the conflict which in some districts had restricted movement of the government's outreach services beyond district headquarters.

The project worked in conjunction with the D(P)HO and NFHP to extend the outreach services to reach disadvantaged, marginalized communities in the most effective and flexible way. The expansion of regular

seasonal VSC services among disadvantaged and marginalized population residing in remote places was highly supported. Coordination meetings were conducted with districts and related health institutions to decide the dates and appropriate sites for the expansion of VSC services. Prior to conducting VSC service in the community, FCHVs were mobilized to ensure the number of clients voluntarily interested in accessing FP services based on informed choice. FCHVs and NGO partners used local media (miking, postering) to disseminate information on service availability and FCHVs collected the names of potential clients based on informed choice. FCHVs also linked the post operative clients with HFs for follow up.

Accomplishments

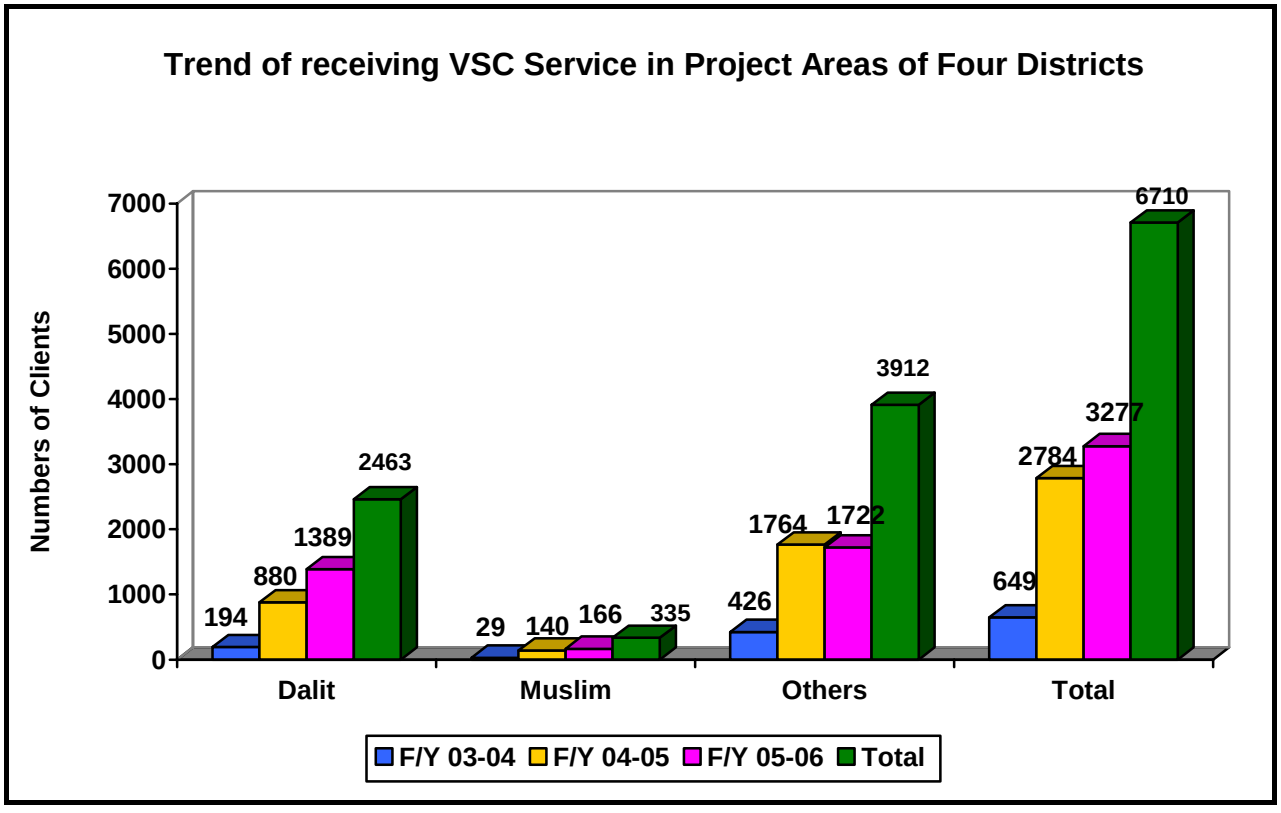
VSC services were expanded in the project area primarily to reach the disadvantaged and marginalized populations of the four districts in coordination with D(P)HOs.

Table 6: Number of clients who received VSC service in Project areas of four districts

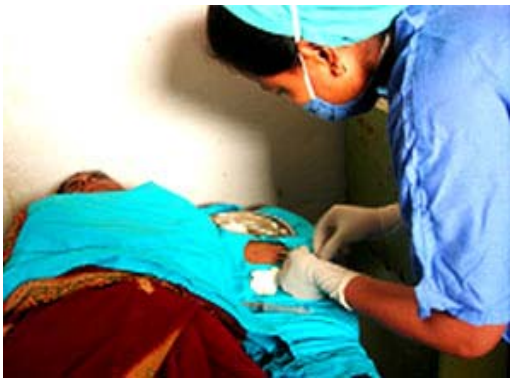
	Dalit	Muslim	Others	Total
F/Y 03-04	194	29	426	649
F/Y 04-05	880	140	1764	2784
F/Y 05-06	1389	166	1722	3277
Total	**2463**	**335**	**3912**	**6710**

The total number of clients who received VSC service in the project areas was 6710 out of which 2463 were from Dalit community, 335 from Muslims community and the rest 3912 were from other castes. The table shows an increasing use of VSC services among all communities. Though there wasn't a high increase among the Muslim community members, the trend, however, significantly showed that service utilization among the Muslim community was increasing.

Figure 4: Trend of receiving VSC Service in Project Areas of Four Districts



Collaboration with Population Services International (PSI) to extend family planning services:



P*LA/RLG member inserting Norplant at HF*

Expansion of Mobile Comprehensive Family Planning services was piloted in collaboration with Population Service International/Nepal (PSI) at two different locations in Siraha District. The aim of the collaboration was to expand the accessibility of services and provide quality services to marginalized populations. Comprehensive family planning services were expanded to marginalized people living in remote areas. The voluntary interested clients were identified from among the PLA/RLG centers as well as the broader marginalized community. There were 193 clients who registered for services out of which 163 received services. However, 33 of them were identified as non eligible for services during the screening process due to their health problem. Out of 163 clients, 141 (86.5%) received minilap service, 20 (12%) received Norplant and 2 received Depo injection. Out of total 163 clients, 71.8 percent were from marginalized communities (Dalit 66.3 percent and 5.5 Muslims). By using the standard checklist, DPHOs and local NGOs followed up with the post operation clients. In addition to the PSI clinic, comprehensive family planning services were provided to marginalized communities of impact VDCs in coordination with DPHOs where a total of 268 clients received Norplant and 69 received IUCD services.

FP service utilization at HFs

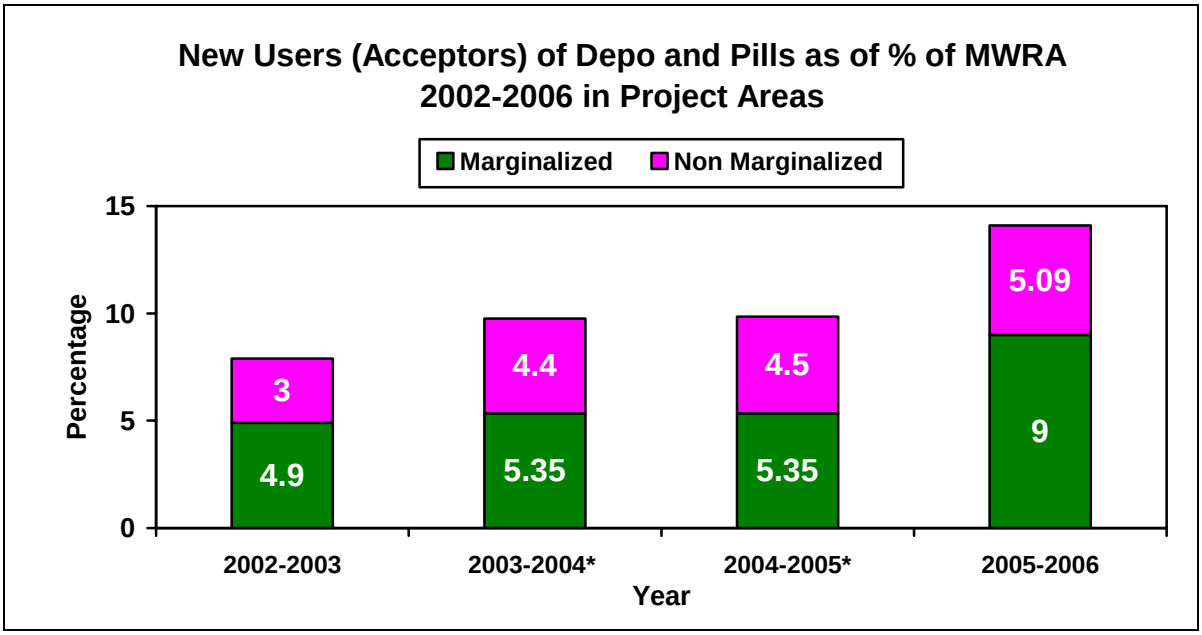
FP service utilization data was collected and monitored from Health Management Information System (HMIS) in the project areas of the four districts. The data was compared on an annual basis. Since the majority of the health facilities in the project areas were sub health posts, the availability of FP services was mostly limited to Pills, Depo injection and condoms. According to the HF service statistics, an increasing trend was noticed in the FP use both among the marginalized and non-marginalized communities of the project districts.

Table 7: New User (Acceptors) of Depo and Pills as of % of MWRA F/Y 2001-06 in Project Areas

F/Y	2002-2003	2003-2004*	2004-2005*	2005-2006
Marginalized	4.9	5.35	5.35	9.00
Non Marginalized	3	4.4	4.5	5.09
Total	**3.7**	**4.8**	**5.4**	**6.63**

** HCP project started*
***Source:** HMIS*

Figure 5: New user (Acceptors) of Depo and Pills as of % of MWRA F/Y 2001-06 in Project Areas



Before program implementation there was no significant change noticed in the status of new users. However, since the start of the interventions a significant increase has been seen in FP users. By the end of the project, there was a noteworthy increase of new users which increased from 4.9% in 2003 to 9% in 2006.

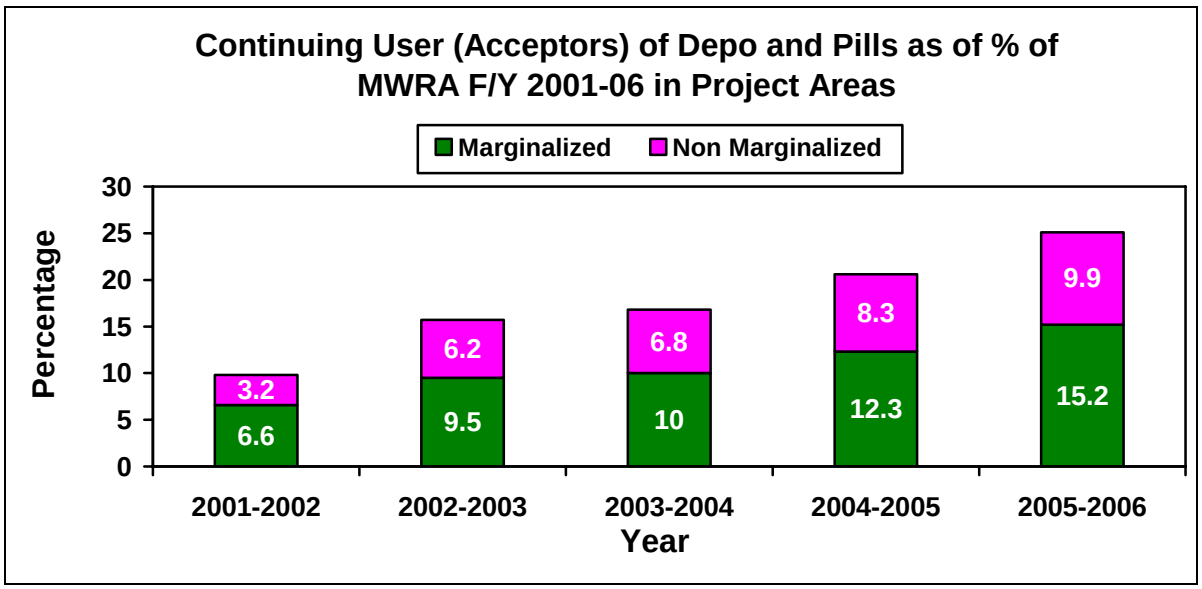
Table 8: Continuing Users (Acceptors) of Depo and Pills as of % of MWRA in the Project Areas

F/Y	'01-'02	02-03	03-04*	04-05	05-06
Marginalized	6.6	9.5	10	12.3	15.2
Non Marginalized	3.2	6.2	6.8	8.3	9.9
Total	**4.5**	**7.5**	**8**	**9.8**	**11.9**

** HCP project started*

Source: *HMIS. The numerator used in calculation is the total # FP user and the denominator is total # of estimated MWRA.*

Figure 6: Continuing Users (Acceptors) of Depo and Pills as of % of MWRA in the Project Areas



The success of the program has been noteworthy. The continuing users of Pills and Depo Provera increased from 8% in 2004 to 11.9% by the end of the project in September 2006. The percentage of new accepters among marginalized population increased from 10% during the start of the project to 15.2% at the end of the project in September 2006. An increasing trend was also noticed among the non marginalized group members from 3.2% in 2002 to 9.9% in 2006.

Couple Year of Protection (CYP):

CYP estimates the couple years of protection provided by family planning services during one year period and is based upon the volume of all contraceptives distributed to clients during that period for condoms, pills and Depo Provera. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which is an estimate of the duration of contraceptive protection provided per unit of the methods.[3] The CYP for each method are then summed over all methods to obtain a total CYP. The CYP are core indicator for monitoring family planning programs. The reason for the increasing CYP rates may be attributed to the project activities, particularly its focus on marginalized populations.

Table 9: Couple's years of protection (CYP) of the project area by method year wise (2001 -2006)

F/Y	01-02	02-03	03-04*	04-05	05-06
Condom	1438	1817	1968	2271	3406
Pills	378	832	1135	1287	1514
Depo	2119	2801	3633	4542	5450
VSC	N/A	N/A	6490	27840	32770
Total	**3935**	**5450**	**13226**	**35940**	**43140**

* HCP project started
Source: HMIS

CYP in the four project districts was found at the increasing trend over the last 4 years. However, a significant increase was noticed in the project area since the start of HCP Project. The CYP of condom increased from 1,438 in 2002 to 3,406 in 2006. Similarly CYP of VSC also increased from 6,490 in 2004 32,770 in 2006. A similar increase was also noticed in CYP of Depo Provera which rise from 2,119 in 2002 to 5,450 in 2006 and also in CYP of Pills which increased from 378 in 2002 to 1514 in 2006 respectively.

The success in family planning use was mainly due to the intensive efforts made by the DPHO and Partner NGOs. At the initial phase of the project, there were lots of rumors and misconceptions regarding FP methods which were identified by Focus Group Discussion. This was misspelled through organizing a monthly interaction program among PLA/RLG participants jointly by PNGO and DPHO staff. This intervention was also successful in identifying community interest as the participants were interested to receive comprehensive FP services as opposed to VSC alone. The forum was also utilized for disseminating messages on comprehensive family planning and thereby linking the potential clients to appropriate health facility As a result comprehensive FP services were expanded in the project sites particularly to cover the intended audience i.e. the poor and marginalized community of the impact VDCs.

[3] *The USAID – accepted conversion factors used here are: Condoms : 120 per unit, Depo Provera : 4 doses per unit, Oral contraceptives : 15 cycles per CYP, IUD: 3.5 per IUD inserted , Norplant : 3.5 per implant inserted, Permanent; 10 year per procedure.*

Voice of a Health Worker

I am Deependra Chaudhary and I work as SHP In-charge at Belha SHP, Siraha. I joined my service from Okhaldhunga district. PLA/RLG participants now have a positive attitude towards our FP program. Though some Muslim communities were not aware about family planning initially, now many of them have learned about it. In the last fiscal year the patient flow at the SHP was low but now a days the numbers are increasing. The current users of family planning has increased considerably. The numbers of marginalized clients visiting health centers are increasing day by day. The current users are more as compared to last year and we acknowledge all the efforts that INSES (NGO) has put to make this happen.

During the course of work I have observed a drastic positive change at Belha SHP such as in infection prevention practices, regular meetings of HFMC/QI team and FCHVs, and cleanliness around and within the SHP. These changes have helped to increase the client flow in the clinic, which never had happened before.

2.4 Improved Social and Policy Environment for FP Services and Behaviors

Approach

Capacity Building

Capacity building of partner NGOs, D(P)HOs, field staff and communities aimed to enhance skills and knowledge and establish plans and processes necessary in order to continue FP activities beyond the life of the project. The project provided a number of skill development workshops to PNGOs, D(P)HOs, field staff and community members which are listed below. The development of plans and processes that will ensure the longevity of the project outcome have been integrated into many of the activities to ensure collective learning and action e.g. community action plans of the PLA/RLG Centers, establishment of Quality Improvement Teams (QIT), integration of marginalized members into HFOMC, prioritized lists of quality improvements by the community and HF staff.

In addition, the capacity of NGO has been strengthened to a point where they are now confident to seek other funding sources to implement the program.

Accomplishments

Close coordination at central, district and community level with stakeholders has been key to giving ownership of the project to the government (both central and district), health workers and the community. The meetings are an essential and regular part of project implementation activities.

Central level: Coordination and program sharing review meetings enabled HCP and stakeholders to share and discuss plans and progress on a monthly basis. The progress of the project was shared with Family Health Division, Director-General of Department of Health Services and NFHP on regular basis, and with the NGO Coordinating Committee (NGOCC).

District Level: Coordination and program review meetings with D(P)HO, NFHP, HCP, USAID and local partners were held on a regular basis to share and discuss plans, progress and problems/issues faced during implementation including solutions to resolve problems. HCP staff participated in District Annual Review meetings and incorporated project activities into the government's district based work plans.

Reproductive Health Coordination Committees (RHCCs) meetings and Quality Assurance Working Group (QAWG) meetings were also appropriate for sharing the project implementation in the four districts. The RHCC and QAWG, composed of both government and NGOs institutions, intended to facilitate the provision of reproductive health services at the district level. The partner NGOs played a lead role in Siraha and Dhanusha to conduct RHCC meetings on a quarterly basis. During Year Two, RHCCs in the four districts met at least quarterly and shared major activities e.g. issues that were raised during PDQ implementation, sharing FP services utilization by caste/ethnicity, PLA/RLGs and expansion of VSC services.

VDC level: Coordination meetings were held with health facilities, Health Facility Operation Management Committees and Quality Improvement Teams, VDCs, FCHVs and PLA/RLG facilitators on quarterly basis to share the plan and progress focusing on quality of FP/RH services. The issues identified from the PDQ approach were discussed during the meeting and solved by mobilizing local resources.

Household Level: Community mobilization was an essential activity conducted for sustainability and to create an enabling environment for the successful implementation of the project. The community members were involved from the initiation of the project including the selection PLA/RLG centers, facilitators, and supervisors and monitoring the PLA/RLG centers. Center Management Committees (CMCs) formed for each PLA/RLG center operate the centers effectively. The CMCs have built huts for PLA/RLG centers,

provided locally made mats, purchased batteries for radios and monitored the participants' attendance in Center

All the members of PLA/RLG of Gautari VDC Ward No. 1, Siraha mobilized their community people and neighbors in the mass awareness rally for the Polio eradication and Vitamin A campaigns 2005 and 2006. The community people went to every house hold in their community and informed them about the campaign and helped in gathering children under 5 years of age for vaccination.

A series of meetings and orientations with community influentials, especially Maulanas (Muslim community leaders), were conducted to address cultural barriers to the fulfillment of reproductive health intentions by Muslims community. For instance, in Banke district Maulanas reviewed the Islamic Dharma Granth Quran (Religious book) to find if there are any religious prohibitions against accepting FP methods. As a result, the Maulanas agreed to allow FP among Muslims in their communities in Banke. Also, through the summary programs of ***Gyanya Shakti Hoy*** drama serial, Maulanas encouraged the adoption of family planning for better maternal and child health over the radio.

Capacity Building of PNGO staff

In order to achieve the project objectives and for the capacity building of PNGO and community, several training were organized during the project period. The training mainly focused on enhancing the capacity of D(P)HO staff, NGO board members & staff and the community members.

1) Program planning, design, monitoring and evaluation (PDME)

A total of 28 participants from four NGOs participated in the workshop primarily aimed at preparing a detailed implementation plan of the project. Participants from D(P)HO also participated in the workshop.

2) Training of Trainers (TOT) on PLA/RLG

A total of 20 participants from D(P)HO and board member/ staff from NGO participated in the PLA/RLG Training of Trainers program. The objective of the training was to prepare a core group of master trainers at NGO /DPHO levels who could conduct PLA/RLG facilitators basic and refresher trainings at the District/VDC level.

3) PLA/RLG facilitator's training

A ten days basic training on PLA/RLG methods and 5 days refresher training was organized for 374 NGO facilitators. Both the trainings were facilitated by NGO staff with technical support from JHU/CCP and SC/US. Out of 374 (3 male, 371 female) participants, 34% were from marginalized population.

4) TOT on PDQ

A four days Training of Trainers on the PDQ approach was provided to 32 participants representing all 4 partner NGOs and DPHOs. The training was on how to conduct the PDQ process.

5) Counseling Training

With a view to enhance the skills of the NGO and DPHO staff on informed choice and family planning counseling, a three days FP counseling training was organized for 20 HWs and NGO staff of project districts. The training was organized in coordination with Regional Health Training Center of MOHP using the National Health Training Center standard training curriculum.

6) Strategic Health Communication and Advocacy workshop

A six days workshop on Strategic Communication and Advocacy was provided to 20 NGO and DPHO staff. The overall goal of the workshop was to enhance the knowledge and skill of the participants in designing, developing, implementing and evaluation strategic communication program to influence behavior change among the intended audiences. The curriculum was based on the Advances in Health Communication workshop organized by JHUCCP in Baltimore. The curriculum was adapted to make it relevant to the Nepalese context. The workshop was facilitated by JHUCCP/NFHP staff.

7) Report writing skill training

In order to build capacity on report writing and documentation, a six day workshop was organized for NGO staff of all project districts. As a result of the training, NGO participants were able to write project reports and success stories. A total of 12 participants attended the training program.

8) Lot Quality Assurance Sampling (LQAS) training

A three days LQAS training was provided to 16 participants from NGOs and DPHOs. The objective of the training was to enable the participants to collect the data from the project and control areas through using LQAS techniques. Following the training, the NGO trainers provided LQAS training to field enumerators.

"The HCP project involved all health facility in-charges in the service utilization data workshop. Due to the lack of skills, we had not been able to analyze the data but after receiving the LQAS training, the concerned staff of health facility center are able to analyze the data and assess the effectiveness of the government and NGO programs for expected beneficiaries. It has also enhanced the capacity of all the staff of health facility center" *says Mr. Rajkumar Yadav, DHO, Siraha.*

9) Supervision and monitoring training

Fifty-six community mobilizers of PLA/RLG received a five-day training on supervision and monitoring.

10) Mobilizing individuals from policy level to national level

A one-day orientation meeting was organized with Moulanas, VDC members, PLA/RLG participants and facilitators to acquaint them to the HCP project and generate their support in program activities.

11) Orientation to PLA/RLG Center Management Committee (CMC)

A total of 2,262 CMC members from 374 PLA/RLG center were oriented about the PLA/RLG program to seek their support for effective running of the Centers. Each CMC included 5-7 persons representing FCHVs, facilitators, teachers, ward leaders and 2 PLA/RLG participants.

12) Maulana Orientation

A total of 49 Muslim religious leaders, community influential and representatives from DPHO participated in the Maulana orientation in Banke district. The orientation gained valuable support from religious leaders for the smooth implementation of promotional Centers on FP at the district level.

13) Orientation on Client exit interviews

Forty-four community mobilizers and staff participated in the orientation program which was primarily focused on conducting client exit interviews effectively at the health facility level. After the orientation, the mobilizers conducted interviews of clients seeking health services at health posts and their degree of satisfaction.

14) Learners' Generated Material (LGM) Development workshop

A total of 14 participants from NGOs, DEO and DHO participated in a Learners Generated Development Workshop. The objective of this workshop was to train the NGO staff on how to mobilize the PLA/RLG participants in developing materials which are clear, understandable and culturally appropriate for neo literate participants. As a result of this workshop PLA/RLG participants were able to develop learning materials based on the knowledge and skills learned from the PLA/RLG session which included stories, case studies and experiences. These materials were used in the post PLA/RLG classes.

15) Coordination meeting with DHO

NGOs organized regular coordination meetings with D(P)HOs and shared about the program, its nature and project areas. They also focused on why and how important the record of marginalized service users was for this program. As a result of that coordination meetings, D(P)HOs circulated the notice letter to the HF In-charges of project area with request to write the last name (CASTE) of every client clearly during registration.

16) Coaching during the supervision visit in HFs

During the supervision visits in HFs, D(P)HO personnel and PNGO staff reviewed registers to check the record of marginalized and coached on the spot to write caste of every clients during registration which provided a clear picture of the service users. The HCP Project staff also took the opportunity of using the QI/HFMOC meetings as a forum to discuss quality related issue.

Sustainability

For the sustainability of the project, a series of capacity building opportunities were provided to NGO staff. As a result they are now in a position to design, plan, implement and monitor BCC programs and PLA/RLG activities with limited technical support from HCP staff. In addition, efforts were made to link PLA/RLG with other on–going programs of the NGOs so that activities could continue beyond the project. The focused support to develop and strengthen the NGO's management system has also enabled NGOS to develop program, procedures and financial policies, establish filing systems and documentation. The project also gave priority to select FCHVs as the PLA/RLG facilitator because they are the permanent community mobilizers. As a result, the FCHV facilitators are continuing their mothers group meetings through using the knowledge and skills which they had gain through training. Similarly, with their enhanced IPC skills, FCHVs are now in a better position to counsel family planning clients effectively. The FCHV's activities has increased their interest and work in FP and has strengthen their role as a bridge between the communities and the health facilities.

The D(P)HO's close involvement in project implementation has meant that activities such as PDQ are linked with HFOMC. A number of activities such as: the establishment of QITs to implement the prioritized list of improvements made through PDQ process, the linkage of QITs to the D(P)HOs and RHCC, and the participation of marginalized people to participate in the QI team and HFOMC has led to the sustainability of the project.

Major activities carried out for project sustainability were as following:

- SAVE linked HCP NGO activity with its on going Sandip program which primarily aims to build the capacity of NGOs so that they can run their programs on their own.
- CWFA Dhanusha provided technical assistance to a local CBOs (Rural Self-Reliant Development Center) on educational materials development and also assisted them to run 24 PLA/RLG groups which were funded by other donor.
- 78 PLA/RLG were merged into mothers group in Siraha (12), Dhanusha (17), Sunsari (31) in Banke which holds a meeting once in a month to discuss on family health topics.

- 17 PLA/RLG centers were merged into the *'Swastha Chautari'*, program of World Education thus giving continuity to group health education program
- The localized radio drama serial has proved to be very effective among the rural audiences of Banke Districts. Based on the demand made by the community, Bageswari FM has been airing the Awadhi version of the phase I drama serial free of cost thus allowing the community to continue to receive health information.
- In Sunsari, UNICEF (DECAW) Decentralized Action for Children and Women have shown their showed interest to involve 5 PLA/RLG groups (126 participants) in their Saving and Credit Program.
- Upon request made by Ministry of Education, Government of Nepal, HCP published 3 types of guide book on PLA approach. This includes training manual, facilitators guide book and implementation guidelines. These materials will be disseminated in large scale and are also expected to be used by other organizations who are interested in implementing PLA group session.

3. Monitoring, Evaluation and Research

The project was monitored through population based survey using Lot Quality Assurance Sampling (LQAS) methodology, reviewing health facility records and PLA/RLG registers, and ongoing monitoring visits, depending upon the indicators. Different tools were developed to monitor and evaluate the project. For example, results indicators planning tool, performance indictors tool, summary implementation plan etc.

Population based surveys

Population based survey, using LQAS methodology, was done to assess the indicators related to knowledge and behavior. Baseline, midterm and final surveys were carried out in the project areas of four districts by mobilizing D(P)HO staff and partner organizations. Survey design, techniques and instruments used for the reproductive health programs were the same as all three surveys. Training was organized in each district for the enumerators and covered topics like sampling, selecting households, interviewing techniques, recording responses reviewing questionnaires, etc. Baseline survey identified the level of indicators and facilitated to set targets against which each indicator would be monitored in follow up surveys. Comparative findings between baseline, mid term and final surveys are appended in **Annex 3(B)** of this document.

LQAS also facilitated in identifying the sub - areas in each district with low and high performance. The project team with key stakeholders worked on identifying reasons for low performance and came up with strategies to overcome these problems.

3.1 Monitoring/Evaluation

Ongoing monitoring

Reviewing facility records was a major activity to monitor the uses of family planning services in an ongoing basis. These records facilitated to assess couple years of protection (CYP), and new and continuing acceptors (by ethnicity).

Regular monitoring and supervision of the project and, in particular, compliance with USAID Population Policies have been conducted by HCP staff (field, regional and central) and PNGO staff. Joint monitoring and supportive supervision have been conducted by NGO Executive board, DHO/DPHO and SC/US on quarterly basis.

PLA/RLG centers received an average of 3-4 monitoring visits per month by project staff. During monitoring visits and meetings, HCP project as monitored compliance by PNGOs of USAID's population policies: Tiahrt Amendment, Helms Amendment and Mexico City policy. PNGOs have taken the compliance of USAID population policies as a job aid. All HFs display the Informed Choice poster. Community mobilizers are enabled to supervise the PLA/RLG centers. On an average 8 PLA/RLG centers were assigned to each mobilizer. Monthly meeting were conducted with the facilitators and supervisors. In addition, quarterly, semi annual and annual program review meetings were conducted with NGOs, D(P)HOs and HCP teams to share progress, issues, challenges and plan on how to over come it, upcoming monthly, quarterly, annually work plans. NGOs have submitted their progress program and financial reports on quarterly basis.

3.2 Research

With a view to assess the effects of PLA/RLG activities for promoting contraceptive use among members of marginalized groups in Nepal, a special study was conducted on PLA/RLG activities. Specially, the study was intended to:

1. Assess whether participants in the PLA/RLGs are more likely to be using a modern contraceptive method compared to women who did not participate in these groups.
2. Assess whether the effects of PLA/RLG on family planning KAP diffused from the PLA/RLG participants to other members of the community.
3. Identify the factors that mediate the relationship between participation in the PLA/RLG and the use of a contraceptive method.

The study was conducted in Sunsari, Dhanusha, Siraha and Banke districts. The study collected retrospective data from a matched sample of intervention and comparison from the project districts. A total of 59 intervention and 20 comparison wards were randomly selected. A total of 1,679 married women aged 15-49 years were included in the study, of which 839 were PLA/RLG members (from Cycle 1 and 2), 420 non-members from program wards and 420 residents of comparison wards which were selected randomly.

Key highlights of the study:

- Overall results indicate that the program has been instrumental in increasing the ability of women in different aspects as a result of their participation in PLA/RLG classes. For instant over 85% of the respondents acknowledged that they became able to use family planning methods and another 76% said that they became able to talk freely in front of a group as a result of participating in PLA/RLGs. Similarly 62% of the respondents (from among 839 members) claimed that they are able to read and write.
- A great majority (84%) of the PLA/RLG members reported that they disseminated their enhanced health knowledge to the community people. The survey results also demonstrate the same i.e. increased FP knowledge, use of family planning among family members of PLA/RLG participants and also FP intensions among non-PLA/RLG members.
- The percentage of respondents currently using any family planning method is significantly higher among PLA/RLG members (44%) than those with non members (36%). The level of contraceptive use among PLA/RLG members has increased significantly from the level of 39% just before the start of the program activities to 51% at the end of the project. Similarly, the CPR among PLA/RLG members of phase 2 has also increased from 32% to 48% by the end of program.
- Regarding the intension of using family planning method, a higher percentage of (86%) of the PLA/RLG members were willing to use family planning method as compared to 68% respondents of control area.
- Discussion on family planning issues between husband and wife was found to be significantly higher among PLA/RLG members and non members than those from control areas. Similarly a higher

percentage of PLA/RLG members than non-members and respondents of control areas reported to have talked about family planning with health care providers.

- Knowledge of family planning was found to be almost universal among the respondents of all three categories (PLA/RLG, Non PLA/RLG and Control Group). However, a higher percentage of the PLA/RLG members compared to non-members and control areas had correct knowledge about all family planning methods i.e. Depo, Norplant, IUD, pills, condom and permanent methods. PLA/RLG members were 11.5 times more likely to have correct knowledge about all family planning methods that other counterpart.

4. Lessons Learned, Best Practices, Challenges and Recommendations

4.1 Lesson Learned

- Nepal has been in a crisis for the past 10 years and suffered from political stability, growing unrest, civil conflict and adverse security situation, creating turmoil in every sector of human development. This unstable situation has been exacerbated by the escalation of tension between political parties and government. Occasional curfews and frequent *bandha (*General Strike) have disturbed a few of the activities due to travel and meeting restrictions. Meeting with VDC chairperson were sometimes postponed as the chairperson stayed at district headquarters and not in VDC due to undesirable situation in the VDC. The political conflict did hamper the meetings with the chair person but somehow meetings were carried out. The following strategies used were: maintaining a low profile, project transparency and in case of tension, **"Wait, Watch and Go"**. Despite the growing conflict and unsafe security situation, the project was able to achieve almost all planned activities.
- Though the political unrest was an impeding factor, the project was able to achieve the objectives and fulfill its work plan by using the following strategy:
  - Program implementation involving a highly participatory approach of D(P)HOs, HP/SHP staff;
  - Hiring only based people as facilitators and mobilizers;
  - Maintaining low presence of outsiders by working with NGOs who maintain relation with the community and through the D(P)HOs;
  - Showing the benefits of the project to the disadvantaged and marginalized groups through tangible results;
  - Developing a synergy among the local partner NGOs, NFHP, JHUCP/SC/US, DHO/DPHO and MOHP. For instance PDQ was implemented jointly with NFHP; and
  - Applying innovative approaches to assist the marginalized to fulfill their reproductive health intensions.
- Focused interventions such as localized radio programs with literacy classes helped to reach the poor and marginalized communities with health messages and influence behavior change.
- It was key to mobilize of Muslim Religious leaders (Maulanas) to address the religious and cultural barriers to FP adoption by the Muslim communities. As a result, Maulanas publicly gave their support to FP adoption for the Muslim community through radio broadcasts.
- The PDQ process built strong partnerships between the community and health facility to improving service quality. It was especially important to include the marginalized populations in the decision making process regarding issues related with quality of health service.
- Demand creation and provision of services should be addressed in a synergistic manner to bring impact. To improve health care seeking behavior and utilization of services, BCC activities should be linked up with health services.

- Comprehensive FP mobile services helped to ensure clients right to informed choice.
- It was felt that to actually see the substantial behavior changes the tenure of three years was not enough time.
- The program (PLA/RLG) was more effective as it was conducted in local languages using the local facilitators whose mother tongue was similar to the community. This enabled a healthy discussion on the topic following the live listening of the radio drama serial.
- Involvement of male participants in the group activity was found more effective on influencing family planning use among their family members. Family planning use was found higher among family members of three PLA/RLG centers in Banke districts where the participants were male.
- Inclusion of marginalized populations in the decision making process or the project was very important to ensure their full participation in the program.

4.2 Best Practices

- Integration of RLG program in PLA activities was regarded as a best approach to reach hard to reach population. This approach was highly appreciated by the D(P)HO, participants and other district stakeholders particularly focusing on marginalized and disadvantage population of project area. The main attraction of the drama serial was that the messages were delivered in an enter-educating format and in local language capturing the cultures of the community.
- Dalits and Muslim community participated together in the group activity thus creating a harmonious relationship. The program also enabled them to read and write.
- Appointment of community based people as facilitators and mobilizers at local level. Due to this, the program was not hampered during the conflict situation where mobility of people was restricted.
- Orientation to Maulana to address the religious and cultural barriers to FP adoption by the Muslim communities.
- Mobilization of local facility health workers on dispelling FP rumors and misconception proved to be very successful. This also helped to develop closeness among the health facility staff and community.
- Relaying experiences of PLA/RLG participants through the radio in drama summary program was found very effective among the participants. This inspired other members of the community to join the groups.

4.3 Challenges

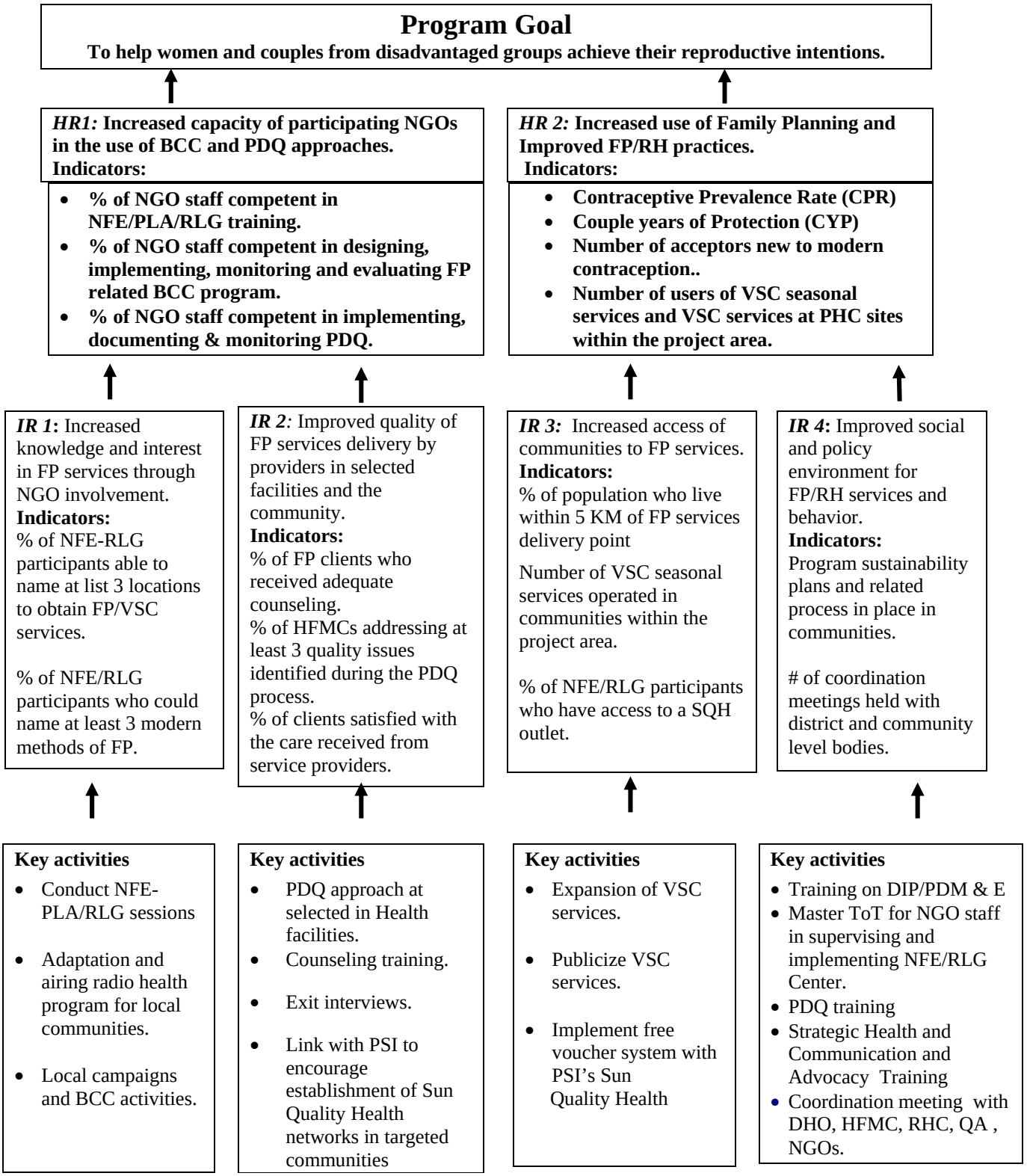
- Regular attendance of participants during harvesting season was seen as a problem as most of the marginalized people are daily wage workers they did not have sufficient time to participate in PLA/RLG Centers.
- Cultural barriers were faced while discussing on FP topics in Muslim communities.
- Absence of VDC level secretary/chair person during PDQ process. Meeting with VDC chairpersons were sometimes postponed as the chairperson stayed in district and not VDC due to unrest situation in the VDC.
- Existing HMIS does not collect data of service utilization by caste/ethnicity as such it was difficult to identify the served population of the community/district.
- Conflict situation: Though the political unrest was an impeding factor that caused a lot of problems the project was able to achieve its objectives and fulfill its work plan. The social/community mobilization activity helped NGO to bring all the people in one forum to minimize their problems as prioritized.

4.4 Recommendations

- Since the target beneficiaries of the HCP are from the poor and marginalized population who have to work hard for their daily livelihood, the program would be effective if PLA/RLG activities are tied up with income generation activities. This would help to ensure regular participation in the program.
- The program should continue for longer period to bring positive long lasting changes among the population.
- The program should be scaled up so that all Dalit and Muslim communities of the selected districts are covered.
- Since men are the primary family decision makers regarding health, program should involve men from the beginning to garner their support.
- In order to ensure flexibility of participant's time, the use of cassette player for drama serial broadcast will be more effective.

Annex : 1

Result Framework



Annex : 2

Target Beneficiaries by District

District	Banke	Dhanusha	Siraha	Sunsari
Total Population	413,972	735,375	616,203	648,045
Total VDCs	46	101	106	49
# of VDCs cover by project	19	11	12	16
Total population of the Impact VDCs	108,112	97,663	56,154	130,252
Target Beneficiaries				
Total marginalized population in impact VDCs	51,354 (47.5%)	26,035 (26.6%)	20,221 (36.01%)	53,185 (40.83%)
# MWRA of the impact VDC	20,866	18,849	10,838	25,139
# Marginalized MWRA in impact VDCs	9,911	5,025	3,903	10,265
Disadvantaged and marginalized caste in the districts	Kurmi, Kami Damai, Dhobi, Pasi, Yadav, Chidimar, Ahir, Teli, Badhi, Lohar Khatik, Kahar, Lodha, Muslim	Chamar, Mushar, Khatwe, Kami, Tatma, Muslim, Paswan, Dhobi, Halkhor, Sonar, Lohar, Dom, Satar, Damai, Yadav, Tharu, Magar, Teli, Badhi, Kahar, Kurmi	Muslim, Mushar, Chamar, Tatma, Dom, Kami	Muslim, Mushar, Sarki Paswan, Lohar, Tatma, Dom, Kami, Damai

Source: Annual Report Department of Health Service 2002/2003 and DDC Profile

** Total MWRA of 58 VDCs = 75692*
** Total MWRA among marginalized population of 58 VDCs = 29104*
** MWRA (15 -49 years women) is constituted 19.3 % of total population.*

Annex: 3A

Indicator Reporting Table for Annual Reports
Part A. Service Statistics (core indicators in bold)

INDICATOR	Number	Dates for covered	Numerator	Denominator	Percent	Confidence interval	Yes/ No	Date source / time covered
Total number of beneficiaries program (MWRA)	75,692 * (Marg. = 29104)							Annual Report Department of Health Service 2002/2003 and DDC Profile
KR 1. Couple-years of protection (CYPs) (per year)	10369 (13.7%)	July '05 – June '06						HMIS Reports July '05 –Jun '06)
KR 2. Number of users new to contraception (per year)	5017** (6.7%)	July '05 – June '06						HMIS Reports July '05 –Jun '06)
R 2.1 % of clients who receive adequate counseling			79	161	49 %			Final survey '06
R 2.2 % of facilities offering three or more methods			58	58	100%	-		HMIS report July '05 –Jun '06)
R 3.1 % of population who live within 5 km of a FP service delivery point			392	513	76.4 %			Final survey '06
R 3.2 % of facilities reporting no stock outs in the last quarter								Indictor is not measured
R 4.1 Program sustainability plan in place							Y	
Optional indicators								

* Total # of beneficiaries is included MWRA of both marginalized & non marginalized population

** New acceptors of Depo & Pills only

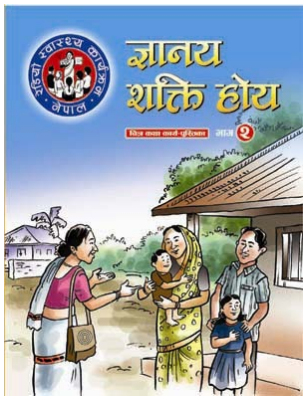
Annex: 3B

Part B. Population-Based Survey Indicators
Baseline, Mid Term and Final Survey

Indicators	Baseline		Mid Term		Final	
	Percent (weighted average)	95 % Confidence Limits	Percent (weighted average)	95 % Confidence Limits	Percent (weighted average)	95 % Confidence Limits
KR 3. Contraceptive use among WRA	33.7	28, 44	33.8	28.4 , 39.2	37.4	+/- 5.5 (32.4, 42.9)
KR 2. Unmet need for family planning						
KR 5. Adequate birth spacing	60.6	N/A	58.3	48.7 , 67.9	52.7	+/- 10.5 (42.2 , 63.2)
R1.1 % of respondents who know about at least three methods of family planning	57.3	52, 63	78.0	73.6 , 82.4	91.3	+/- 2 (89.3 , 93.3)
R1.2 % of mothers with children < 12 months who received counseling about birth spacing						
R1.3 % of sexually active respondents who report discussing FP with their spouse or sexual partner in the past 12 months	46.8	41, 52	33.6	28.6 , 38.6	37.37	+/- 5 (32.4 , 42.4)
R2.1 % of respondents who received adequate counseling	50.2	40, 60.5	44.7	35.2 , 54.2	47.8	+/- 9 (38.8 , 56.8)
R3.1. % of beneficiaries that live within 5 kilometers of a family planning service delivery point	62.6	56, 69	73.2	68.1, 78.3	66.8	+/-
R3.3 % of respondents of reproductive age who report discussing family planning with a health or Family planning workers or promoter in the past 12 months	37.5	32, 43	30	25.2 , 34.8	35.1	+/-5 (30.1 , 40.1)
Optional indicators						
% of women who had heard / seen about FP from at least one of the media sources.	60.6	56, 65	46.2	41 , 51.4	69.8	+/- 4 (65.8, 73.8)
% of women aware on at least 3 FP outlets	43.5	38, 49	68.0	63 , 73	68.7	+/- 4 (64.7, 72.70)
% new acceptors to modern contraception	74.8	N/A	73.7	65.3 , 82.1	81.1	+/- 7 (74.1, 94.1)
% of women who have listened to Radio Health Program.	N/A	N/A	17.8	13.8 , 21.8	47.1	+/- 5 (42.1 , 52.1)

Annex : 4

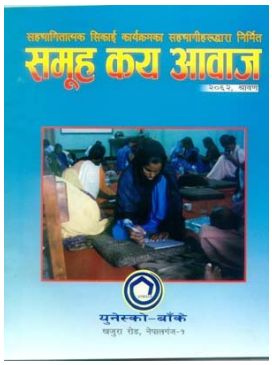
Materials Developed under HCP Project:

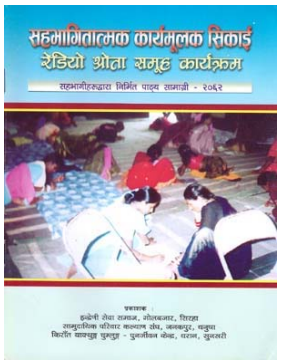


Localized Illustrated work book *used by PLA/RLG participants during group facilitative discussion*

Acknowledgement Sticker *provided to PLA/RLG participants who regularly listened to the radio drama serial. .*

Program Promotional Bags *provided to the listeners who participated in the radio unit quiz program and gave correct answer or send articles, experiences through letters.*





Learning materials *developed by the participants who graduated from PLA/RLG centers. The materials were developed through using LGM approach*

Posters *used in the PLA/RLG classes by the facilitator. The posters were effective to initiate discussion on session topic.*

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